

CHANGE REQUEST FORM

Public Employee Voluntary Life Insurance Policy V256032

Employer: _____

Name of Employee: _____

Employee's Social Security Number: _____

Name of Insured: (if other than Employee) _____

Primary Beneficiary(ies)

<i>Name</i>	<i>Date of Birth</i>	<i>SSN</i>	<i>Relationship</i>	<i>% in whole # to equal 100%</i>

Contingent Beneficiary(ies)

<i>Name</i>	<i>Date of Birth</i>	<i>SSN</i>	<i>Relationship</i>	<i>% in whole # to equal 100%</i>

Cancel Coverage:

Employee Coverage _____
please initial

Spouse Coverage _____
please initial

Dependent Child _____
please initial

AD&D Coverage _____
please initial

Reduce Coverage to:

Employee Coverage _____
Coverage Amount Desired

Spouse Coverage _____
Coverage Amount Desired

Dependent Child Coverage _____
Coverage Amount Desired

AD&D Coverage _____
Coverage Amount Desired

Name Change to: _____

Address Change: _____

SIGNATURE: _____

Date: _____

Mail to: Western Insurance Specialties
P.O. Box 12910
Reno, NV 89510: For Questions Call 775-826-2333 opt 1
Fax # 775-826-2390: Email: service@wisnv.com