Please retain a copy for insured.

REQUEST FOR CHANGE

ADVANCE Insurance Company of Kansas*
1133 S.W. Topeka Boulevard, Topeka, KS 66629-0001
Phone in Topeka (785)273-9804, in Kansas (800)530-5989
Fax (785)290-0727 website: www.advanceinsurance.com

Advance Insurance Company of Kansas is requested to make the following changes in connection with my insurance under:

Employer _____ Group number _____

Printed name of insured _____ S.S. # _____
Last First M.I.

Insured name change

From: _____
Last First M.I.

To: _____
Last First M.I.

Due to: ☐ Marriage ☐ Divorce ☐ Other (explain) _____ Date _____

Beneficiary change

***The **Primary beneficiary** receives your death benefit. If naming two or more beneficiaries, proceeds will be paid in equal shares unless stated otherwise. If listing a minor, proceeds will be paid to a conservator appointed by the court system on behalf of child. **If this space is inadequate for your beneficiary(ies), attach a separate signed and dated list providing complete information.**

	Last	First	MI	Relationship	Date of Birth	City, State
***Primary beneficiary**						

****The Contingent beneficiary, below, will receive the death benefit **ONLY** if the primary beneficiary is deceased.

	Last	First	MI	Relationship	Date of Birth	City, State
****Contingent beneficiary**						

Benefit change

☐ Add ☐ Remove Basic Term Life and AD&D for employee – effective date _____

☐ Add dependent life benefit – effective date _____

Date spouse acquired _____ Does your spouse work for the above employer? ☐Yes ☐No

Date first child acquired _____

☐ Remove dependent life benefit — effective date _____

Note: Marking this box removes dependent life coverage for all dependents, which includes spouse and **all** eligible children.

☐ Add ☐ Remove Short Term Disability (group or voluntary) for employee — effective date _____

☐ Add ☐ Remove Long Term Disability (group or voluntary) for employee — effective date _____

☐ Add ☐ Remove Other (which benefit?) _____ — effective date _____

Reason for change: _____

Class Change

From class _____ To class _____ Effective date _____

Reason for class change: _____

Authorization — signature and date always required

I hereby apply for amendment of my enrollment as indicated on this form. I understand that if I want to add the benefit at a later date I must complete a form asking medical questions and that AICK may request other information to determine whether or not I may be insured under the group program. I understand that I will be responsible for any fees or cost including, but not limited to, obtaining medical records or an exam necessary to determine insurability and that AICK may refuse to cover me (or my dependent, if applicable). I understand that I must be actively at work before a benefit can be added. It is mutually agreed that such change shall not become effective unless and until accepted, and that this request for change will become a part of my original enrollment form and will be subject to the terms of the group policy.

_____ _____ _____
Signature of Insured Date Policyholder/Employer sign here

*An Independent Licensee of the Blue Cross Blue Shield Association