Please retain a copy for insured.



REQUEST FOR CHANGE

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 Insura Employer	nce Company of Kansas is re	equested to make the	e following c		Group number		
Printed name of insured					S.S. #		
Insured name	e change		First		M.I.		
From:	_						
То:	Last		First		M.I.		
Due to: Marriage Divorce Other (explain)		or (ovaloin)	First		M.I. Date		
Due to. Ma	amage Divoice Dou	er (explain)			Date		
Beneficiary of	change						
unless stated or	beneficiary receives your of therwise. If listing a minor, inadequate for your benef	proceeds will be pa	id to a cons	servator appoint	ted by the court syste	em on behalf of child.	
*Primary beneficiary	Last	First	MI	Relationship	Date of Birth	City, State	
	Last	First	MI	Relationship	Date of Birth	City, State	
	Last	First	MI	Relationship	Date of Birth	City, State	
**The Conting	gent beneficiary, below, will	receive the death b	enefit ONI	$oldsymbol{Y}$ if the primar	y beneficiary is decea	ased.	
**Contingent beneficiary	Last	First	MI	Relationship	Date of Birth	City, State	
				•		•	
	Last	First	MI	Relationship	Date of Birth	City, State	
	Last	First	MI	Relationship	Date of Birth	City, State	
Benefit chan	ge						
☐ Add ☐ Ren	move Basic Term Life and A	D&D for employee -	– effective da	ite			
Add depend	lent life benefit – effective d	late					
Date spouse acquired			_ Does yo	Does your spouse work for the above employer?			
Date first c	hild acquired		_				
	endent life benefit — effective						
	ing this box removes depend		-			gible children.	
	move Short Term Disability move Long Term Disability	~ ·	1 ,		-		
	move Other (which benefit?)		1 ,	effective date effective date			
Reason for char	` ,			=	· ·		
Class Chang							
	To cl	ass		Effective da	ate		
Reason for class							
		alwaye roquiro	1				
I hereby apply f must complete insured under t medical records I understand the effective unless	n — signature and date for amendment of my enrolling a form asking medical quest the group program. I under a sor an exam necessary to detact I must be actively at wor and until accepted, and that the group policy.	ment as indicated or tions and that AICk stand that I will be termine insurability rk before a benefit	this form. It may reque responsible and that AIC can be adde	st other information any fees or one of the control	ation to determine we cost including, but no cover me (or my de vagreed that such ch	hether or not I may bot limited to, obtainin pendent, if applicable) ange shall not becom	
	Signature of Insured		Date		Policyholder/En	nployer sign here	