REQUEST FOR CHANGE
GROUP LIFE, SHORT TERM DISABILITY AND LONG TERM DISABILITY

Unum Life Insurance Company of America

Please Print or Type — Press Pen Firmly

To The Employee: Complete this form for name changes, changes in coverage for yourself or your dependents or beneficiary changes. If you are adding dependents because of marriage or birth of a child, complete this form within 31 days after the event.

To The Employer: For all changes except beneficiary changes, send this form to Unum Life Insurance Company of America with your next premium payment. For beneficiary changes, keep the completed form in your files. Our claims department will request the most recent beneficiary information if a life insurance claim is filed.

Complete numbers 1 through 5 and 10 for all changes

1. Name of Company	2. Policy Number	3. Division Number
IIANC Member Services, Inc.	530465	

4. Employee's Name (Last, First, Middle Initial)	5. Social Security Number

Complete numbers 6 and 10 if name has changed.

6. Change Employee's Name

From	To	As of (date)

Complete numbers 7 and 10 for changes in employee coverage and numbers 8 and 10 for changes in dependent coverage.
Note: Discontinuance of coverage for the primary insured will result in the discontinuance of coverage for all dependents (spouse/child).

7. Employee Coverage - Check the appropriate statement.

☐ Discontinue the following coverages:
- ☐ All
- ☐ Employee Life/Accidental Death & Dismemberment
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Other
- ☐ Select Disability
- ☐ Select STD

☐ Add the following coverages:
- ☐ All
- ☐ Employee Life/Accidental Death & Dismemberment
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Other
- ☐ Select Disability
- ☐ Select STD

8. Dependent Coverage - Check the appropriate statement.

☐ I decline dependent coverage at this time. (Note: You can decline dependent coverage only if you pay part or all of the premium. If you decline coverage for your dependents now but want to cover them at a later date, you will be required to furnish evidence of insurability at your own expense, and Unum Life Insurance Company of America will have the right to refuse your request.)

☐ Remove all of my dependents from my plan.

☐ Remove the dependents listed below from my plan as of (date)_____ .

Dependent's Full Name	Relationship	Date of Birth (month/day/year)	Reason Removed

☐ Add the dependents listed below to my plan as of (date)_____ . ☐ Date of marriage (if applicable)_____.

Dependent's Full Name	Relationship	Date of Birth (month/day/year)	Reason Added

Complete numbers 9 and 10 to change beneficiaries. To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for assistance. This beneficiary change cancels and supersedes previous designations and may be changed upon written request.

9. As of (date)_____ , beneficiary should be:

Name	Address	Relation

10. Sign below for all changes

X _____ _____

Employee's Signature Date