K·C·L GROUP BENEFITS

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

CHANGE OF INFORMATION REQUEST

To change information concerning your coverage please complete the appropriate section and return to your employer.
HIGHLIGHTED AREAS ARE COMPLETED BY EMPLOYER.

EMPLOYER NAME	GROUP POLICY NO.
EMPLOYEE NAME (First, Middle Initial, Last)	
SOCIAL SECURITY NO.	Personal Identification Number *(home office use only)*

☐ CHANGE OF NAME

FORMER NAME (First, Middle Initial, Last)	PRESENT NAME (First, Middle Initial, Last)

DATE OF CHANGE (MM/DD/YYYY) REASON FOR CHANGE ☐ MARRIAGE ☐ DIVORCE ☐ OTHER _____

☐ CHANGE OF INSURED BENEFITS

CHANGE CLASS FROM TO

CHANGE SALARY FROM $ ☐ per month ☐ per week TO $ ☐ per month ☐ per week

NEW JOB TITLE EFFECTIVE (MM/DD/YYYY)

AUTHORIZED BY DATE SIGNED (MM/DD/YYYY)

☐ CHANGE OF DEPENDENTS INSURANCE ☐ LIFE ☐ VOL LIFE ☐ DENTAL ☐ VOL DENTAL ☐ VISION ☐ VOL VISION

I WISH TO: ☐ ADD ☐ TERMINATE INSURANCE ON THE FOLLOWING DEPENDENT(S):

NAME (Show last name if different)	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO.
SPOUSE		-		
1. CHILD				
2. CHILD				

MUST SHOW DATE DEPENDENT ACQUIRED OR TERMINATED (MM/DD/YYYY) _____

REASON FOR CHANGE ☐ MARRIAGE ☐ DIVORCE ☐ OTHER _____

(If coverage is contributory evidence of insurability must accompany this form when adding dependent(s) more than 31 days after the dependent is acquired.)

☐ CHANGE OF ADDRESS – COMPLETE ONLY IF ENROLLED FOR **DENTAL** COVERAGE

STREET APT

CITY STATE ZIP

SIGNATURE

I hereby request Kansas City Life to update my insurance records to reflect the changes indicated and authorize deduction of any required cost from my earnings.

SIGNATURE _____ DATE SIGNED (MM/DD/YYYY) _____