



GROUP BENEFITS

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 <i>(home office use only)</i>

**CHANGE OF NAME**

FORMER NAME (First, Middle Initial, Last)	PRESENT NAME (First, Middle Initial, Last)
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DATE OF CHANGE (MM/DD/YYYY) REASON FOR CHANGE  MARRIAGE  DIVORCE  OTHER \_\_\_\_\_

**CHANGE OF INSURED BENEFITS**

CHANGE CLASS FROM	TO
CHANGE SALARY FROM \$ <input type="checkbox"/> per month <input type="checkbox"/> per week	TO \$ <input type="checkbox"/> per month <input type="checkbox"/> per week
NEW JOB TITLE	EFFECTIVE (MM/DD/YYYY)
AUTHORIZED BY	DATE SIGNED (MM/DD/YYYY)

**CHANGE OF DEPENDENTS INSURANCE**  LIFE  VOL LIFE  DENTAL  VISION  ACCIDENT  LOW  MEDIUM  HIGH  CRITICAL ILLNESS

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 OR VISION OR ACCIDENT 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) \_\_\_\_\_