



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)
---	--

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) _____