



REQUEST FOR CHANGE

Unum Life Insurance Company of America
 2211 Congress Street
 Portland, Maine 04122

Instructions Section 1 Must be completed for all types of changes requested	1	Employer (Firm Name and Street Address) City State Zip Code
	(City, State, Zip)	Plan Number Division Number
	Employee Name (Last, First, Middle Initial)	Social Security Number
	Employee Address	

Section 2 Beneficiary Change Request <ul style="list-style-type: none"> • Beneficiary(ies) Name(s) should be given: eg. Smith, Mary J./not Smith, Mrs. John J. • A witness signature must be obtained. <p>*Please give name of Plan if beneficiaries are Trustees of Pension Plan.</p> <p>All Beneficiary Change Requests are to be maintained for your files.</p>	2	Change my beneficiary(ies) as of: _____
	To: Name (Last, First, Middle Initial)	%* Relationship
	If beneficiary(ies) above not living, then pay	
	<p>*Surviving beneficiaries will be paid equally unless otherwise indicated. The change will be effective in accordance with the Group Plan. This beneficiary change cancels and supercedes previous designations and may be changed upon written request.</p>	
		Witness Signature _____ Date _____

Section 3 Tobacco/No-Tobacco Rate Change Request	3	Check one: <input type="checkbox"/> I have not used tobacco products in the last 12 months. <input type="checkbox"/> I have begun using tobacco products.
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Section 4 Dependent Coverage Request <ul style="list-style-type: none"> • Employee must complete this section only if this coverage is available. 	4	<input type="checkbox"/> I request that coverage be added under the Group Plan for: <input type="checkbox"/> Spouse /Marriage date: _____ Attach completed Lifestyle Application or Enrollment Form. <input type="checkbox"/> Child /Birthdate: _____ Life Amount \$ _____ AD&D Amount \$ _____ If requesting dependent coverage, more than 31 days after the date of eligibility, an Evidence of Insurability form must be submitted with the Lifestyle Life enrollment form.
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Section 5 Decrease Amount or Discontinue Coverage Request	5	Decrease the amount or Discontinue coverage for: Reason _____ Date of Decrease or Discontinuance _____ Date _____			
	Insured	Decrease Amount To:	Discontinue Coverage For:		
		Life AD&D	Life AD&D LTD		
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children	\$ \$ \$ \$ \$ \$	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

Section 6 Name Change Request	6	Name Change as of: _____ From: _____ To: _____

Employee Signature _____ Date _____

This form is to be forwarded to UnumProvident with your Lifestyle Protection Group Premium Report.