AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate Benefits

Request for Change Form

Please Print Clearly

EMPLOYER NAME	GROUP NUMBER
EMPLOYEE'S NAME Last (Sr, Jr, etc) First M.I.	SOCIAL SECURITY NUMBER OR CERTIFICATE NUMBER

☐ **CHANGE NAME** ☐ Employee ☐ Dependent If a dependent, complete the information below:

_____ *Relationship* _____ *Social Security Number*

Change Name From: _____ To: _____

Please Provide the Reason for the Change: _____

☐ **CHANGE ADDRESS** ☐ Employee ☐ Dependent - *Name of Dependent:* _____

To: _____ *STREET or P.O. BOX* _____ *CITY* _____ *STATE* _____ *ZIP*

☐ **CHANGE OF BENEFICIARY:** I hereby request, subject to the terms of the Group Policy whose Group number is indicated above, that the beneficiary for the Life Insurance or Accidental Death and Dismemberment Insurance, if any, provided under such Group Policy be changed as shown below. Any beneficiary designation and/or settlement designations previously made is hereby revoked.

PRIMARY BENEFICIARY *(To receive Proceeds if living at the Insured employee's death)*

COMPLETE NAME OF PRIMARY BENEFICIARY	RELATIONSHIP TO INSURED EMPLOYEE

CONTINGENT BENEFICIARY *(To receive Proceeds if living at the Insured employee's death and if Primary Beneficiary is not living)*

COMPLETE NAME OF CONTINGENT BENEFICIARY	RELATIONSHIP TO INSURED EMPLOYEE

☐ **ADD COVERAGE** for Dependent(s), as requested on the fully completed **Dependent Enrollment Form** attached.

☐ **TERMINATE COVERAGE** as indicated below:
TYPE OF COVERAGE: 1. MEDICAL 2. DENTAL 3. CANCER 4. ACCIDENT 5. HOSPITAL INDEMNITY 6. CRITICAL ILLNESS

RELEVENT PERSON	NAME	SOCIAL SECURITY NUMBER	TYPE OF COVERAGE	REASON FOR TERMINATION	DATE OF TERMINATION
EMPLOYEE					
SPOUSE					
DEP. CHILD					
DEP. CHILD					
DEP. CHILD					

Medical Coverage Only: I understand that if I am terminating the group health coverage for me or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to re-enroll myself or my dependents in this health plan, provided that I request enrollment within 30 days after the other coverage ends.

All Coverages: If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll all of my dependents for health coverage, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

☐ **SMOKING STATUS CHANGE for** ☐ **EMPLOYEE or** ☐ **SPOUSE:** Current Tobacco Use:

☐ NONE ☐ CIGARETTES ____ PER DAY ☐ CHEWING TOBACCO ☐ OTHER _____

Have you ever smoked cigarettes? ☐ YES ☐ NO If "Yes," date late cigarette smoked _____

Date Signed _____ Employee's Signature _____

AWD G5004-1