

Request for Service Life Change Form Group Universal Life (GUL) Insurance

NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC



GROUP BENEFIT
SOLUTIONS

| | | | | | |
|-------------------|---------------|------------|---|----------------|-----------------------|
| Last Name | | First Name | | Middle Initial | Certificate No. |
| Mailing Address | | | | | Residence Telephone # |
| City | State | Zip Code | Employer Name | | |
| Social Security # | Date of Birth | Sex | <input type="radio"/> Male <input type="radio"/> Female | | Daytime Telephone # |

ABOVE SECTIONS MUST BE FULLY COMPLETED

A. Name change of: Insured Owner / Certificate Holder Other _____

From: (First, Middle, Last) _____

To: (First, Middle, Last) _____

Reason for Change: _____

* B. Change the amount of insurance coverage to \$ _____

* C. Add / Cancel coverage for my dependent children in the amount of \$ _____ Add Cancel

If cancel - is this your last dependent child? Yes No * Medical Information may be required

| | | | |
|------|-----------|---------------------------|------------------------------|
| Name | Birthdate | <input type="radio"/> Add | <input type="radio"/> Cancel |
| Name | Birthdate | <input type="radio"/> Add | <input type="radio"/> Cancel |

D. My dependent child is no longer eligible for coverage as of the following date (Mo., Day, Yr.): _____
Please send rates and enrollment information for a separate certificate for that child.

E. Change the monthly contribution to my Cash Accumulation Fund.

Employee Increase Decrease New Amount \$ _____

Spouse Increase Decrease New Amount \$ _____

F. Add a lump sum contribution to my Cash Accumulation Fund (Check enclosed) Amount: \$ _____
(Please note all lump sum contributions are subject to a state premium tax and IRS Guidelines)

* G. Add/Cancel the Accelerated Payment Benefit ** Add Cancel * Medical Information may be required

* H. Add/Cancel the Automatic Increase Option ** Add Cancel **Please refer to Coverage Option Page of enrollment booklet if an applicable benefit.

* I. Add/Cancel the Accident Death Benefit ** Add Cancel

J. Change my address to: _____

K. I am terminating my employment and wish to be billed at my home.

L. I wish to: _____

* M. I want to change my coverage due to a Life Status Change. The Life Status Change is: _____
Date of event: _____ Type of change requested: _____

I authorize the above changes to my Group Universal Life coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to make the appropriate payroll deductions for changes noted above. (Does not apply to those being billed at their home).

Owner's Signature: _____ Date: (Mo., Day, Yr.): _____