Voluntary Term Life Insurance Change Form

NYL GBS Customer Service Center
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NEW YORK LIFE GROUP BENEFIT SOLUTIONS

CLEAR FORM

- The applicant must sign and date this form.
- This form cannot be considered unless received within 30 days of the date it is dated.
- This form can only be used for employee-paid coverages.
- **Important:** Please enter all dates in mm/dd/yyyy format.

Please print (preferably in black ink).

EMPLOYEE SECTION

Check one: ☐ Mr. ☐ Mrs. ☐ Ms.

Name: *(First)* _____ *(Last)* _____ Social Security #: _____ Birthdate: _____

Address: *(Street)* _____ *(City)* _____ *(State)* _____ *(Zip)* _____

Work Phone: _____ Home Phone: _____ Employee ID #: _____ Sex: ☐ M ☐ F

I WISH TO MAKE THE FOLLOWING CHANGES TO MY VOLUNTARY TERM LIFE INSURANCE COVERAGE

See your life insurance brochure for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure.

CHECK THE APPROPRIATE BOXES:

I want to change my coverage due to a Life Status Change. The Life Status Change is: _____

Date of Event: _____ Type of change requested: _____

☐ **Cancel coverage on the following individuals:**
- ☐ Employee Effective Date of Cancellation: _____
- ☐ Spouse Effective Date of Cancellation: _____
- ☐ Child(ren) Effective Date of Cancellation: _____

☐ **Change coverage on the following individuals as indicated below:**
- ☐ Employee ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____
- ☐ Spouse ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____
- ☐ Child(ren) ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____

☐ **Name Change:**
- ☐ Employee ***Current*** Name: _____ ***New*** Name: _____
- ☐ Spouse ***Current*** Name: _____ ***New*** Name: _____

☐ **Cancel the Automatic Increase Option**

Reminder: If you'd like to designate new beneficiaries, please go on-line or complete a Beneficiary Form.

ACCEPTANCE / DECLINATION

I authorize the above changes to my Voluntary Term 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.

Signature:	Date *(mm/dd/yyyy)*:
X	

CLICK TO PRINT

Be sure to make a copy for your own records