Group Change Form

Please retain a copy for the insured.

Advance Insurance Company of Kansas (AICK) is requested to make the following changes in connection with my insurance under:

Employer Name _____ AICK Group Number _____ Class _____

Section 1 – Insured Information (always complete this section) CLEAR DATA

Insured's First Name _____ MI _____ Insured's Social Security Number _____-_____-_____

Insured's Last Name _____ Suffix _____

Section 2 – Change of Name for Insured

Change insured's name to: Reason for change: ☐ Marriage ☐ Divorce ☐ Other

First Name _____ MI _____ Explanation for Other _____

Last Name _____ Suffix _____ Date of Occurrence _____ /_____ /_____

Section 3 – Class Change

Change from Class _____ to Class _____ _____ /_____ /_____
Effective Date

Reason for Change _____

Section 4A – Change of Primary Beneficiary

Only the insured may change the beneficiary. The change of beneficiary must be received prior to the insured's death and will be effective as of the date it is received by the AICK home office.

This change of beneficiary will apply to all benefits with AICK. If it does not, indicate which benefits the change applies to:

- ☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)
- ☐ Voluntary Term Life (and AD&D, if applicable)
- ☐ Voluntary Employee Accident/Family Accident

Primary beneficiary information: The primary beneficiary receives the benefit upon the death of the insured. The proceeds will be paid in equal shares to the person(s) shown below unless you state otherwise. If you need additional space, attach a separate signed and dated sheet with complete information.

Beneficiary First Name _____ MI _____ Date of Birth _____ /_____ /_____ or Age _____

Beneficiary Last Name _____ Suffix _____ Relationship to Applicant _____

Beneficiary First Name _____ MI _____ Date of Birth _____ /_____ /_____ or Age _____

Beneficiary Last Name _____ Suffix _____ Relationship to Applicant _____

Beneficiary First Name _____ MI _____ Date of Birth _____ /_____ /_____ or Age _____

Beneficiary Last Name _____ Suffix _____ Relationship to Applicant _____

Please continue on the next page.

Section 4B – Change of Contingent Beneficiary

Only the insured may change the beneficiary. The change of beneficiary must be received prior to the insured's death and will be effective as of the date it is received by the AICK home office.

This change of beneficiary will apply to all benefits with AICK. If it does not, indicate which benefits the change applies to:

- ☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)
- ☐ Voluntary Term Life (and AD&D, if applicable)
- ☐ Voluntary Employee Accident/Family Accident

Contingent beneficiary information: The contingent beneficiary receives the benefit only if the primary beneficiary(ies) in Section 4A is/are deceased. If more than one contingent beneficiary is listed below, the proceeds will be paid in equal shares to the person(s) shown below unless you state otherwise. If you need additional space, attach a separate signed and dated sheet with complete information.

_____ _____ _____ / _____ / _____ or _____
Beneficiary First Name MI Date of Birth Age

_____ _____ _____
Beneficiary Last Name Suffix Relationship to Applicant

_____ _____ _____ / _____ / _____ or _____
Beneficiary First Name MI Date of Birth Age

_____ _____ _____
Beneficiary Last Name Suffix Relationship to Applicant

_____ _____ _____ / _____ / _____ or _____
Beneficiary First Name MI Date of Birth Age

_____ _____ _____
Beneficiary Last Name Suffix Relationship to Applicant

Section 5 – Benefit Change

☐ Add Dependent Life _____ / _____ / _____ Effective Date _____ / _____ / _____ Date of Marriage _____ / _____ / _____ Date First Child Acquired

☐ Remove these benefit(s): _____ / _____ / _____ Effective Date

- ☐ Basic Term Life and AD&D for you
- ☐ Basic Dependent Life
  (NOTE: Marking this box removes all dependent life coverage for all dependents, which includes your spouse and all eligible children.)
- ☐ Voluntary Term Life (and AD&D, if applicable) for:
  ☐ You ☐ Your spouse ☐ All eligible children
- ☐ Voluntary Employee Accident/Family Accident
- ☐ Short Term Disability (Basic or Voluntary) for you
- ☐ Long Term Disability (Basic or Voluntary) for you

_____
Reason for Change

Please continue on the next page.

Section 6 – Authorization

I hereby apply for amendment of my enrollment as indicated on this form. I understand that if I want to add the benefit at a later date I may have to complete a form asking medical questions and that AICK may request other information to determine whether or not I may be insured under the group program. I understand that I will be responsible for any fees or cost including, but not limited to, obtaining medical records or an exam necessary to determine insurability and that AICK may refuse to cover me (or my dependent, if applicable). I understand that I must be actively at work 1) performing all the normal duties of my job, 2) at the usual place, and 3) for the required hours each week before a benefit can be added. It is mutually agreed that such change shall not become effective unless and until accepted, and that this request for change will become a part of my original enrollment form and will be subject to the terms of the group policy.

Your signature required

_____ Insured Employee Signature

_____ / _____ / _____ Date Signed

_____ Insured Employee Printed Name

_____ - _____ - _____ Social Security Number

Group signature required

_____ Group Policyholder/Participating Employer Signature