

<p>Instructions</p> <p>Section 1</p> <p>Must be completed for all types of changes requested</p>	1	Employer (Firm Name and Street Address) (City, State, Zip) Plan Number Division Number Employee Name (Last, First, Middle Initial) Social Security Number Employee Address																													
<p>Section 2</p> <p>Beneficiary Change Request</p> <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><small>*Please give name of Plan if beneficiaries are Trustees of Pension Plan.</small></p> <p>All Beneficiary Change Requests are to be maintained for your files.</p>	2	Change my beneficiary(ies) as of: _____ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">To: Name (Last, First, Middle Initial)</td> <td style="width:15%;">%*</td> <td style="width:25%;">Relationship</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> If beneficiary(ies) above not living, then pay _____ <p><small>*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.</small></p> _____ Witness Signature Date	To: Name (Last, First, Middle Initial)	%*	Relationship																										
To: Name (Last, First, Middle Initial)	%*	Relationship																													
<p>Section 3</p> <p>Tobacco/No-Tobacco Rate Change Request</p>	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.																													
<p>Section 4</p> <p>Dependent Coverage Request</p> <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.																													
<p>Section 5</p> <p>Decrease Amount or Discontinue Coverage Request</p> <p><small>Note: Discontinuance of coverage for the primary insured will result in the discontinuance of coverage for all dependents (spouse/child).</small></p>	5	Decrease the amount or Discontinue coverage for: Reason _____ Date of Decrease or Discontinuance _____ Date _____ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th rowspan="2">Insured</th> <th colspan="2">Decrease Amount To:</th> <th colspan="3">Discontinue Coverage For:</th> </tr> <tr> <th>Life</th> <th>AD&D</th> <th>Life</th> <th>AD&D</th> <th>LTD</th> </tr> <tr> <td><input type="checkbox"/> Self</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Children</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Insured	Decrease Amount To:		Discontinue Coverage For:			Life	AD&D	Life	AD&D	LTD	<input type="checkbox"/> Self	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Children	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Children	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																										
<p>Section 6</p> <p>Name Change Request</p>	6	Name Change as of: _____ From: _____ To: _____ _____ Employee Signature Date																													

For all changes, except beneficiary only changes, forward this form to Unum with your Lifestyle Protection Group Premium Report.

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