



Life / Long Term Care Insurance
 CHANGE FORM
 (Payroll Deduction Authorization)

_____ Change
 _____ Cancel & Termination

(Check Desired plan(s) and coverage)

_____ING Life	_____Post Retirement Life	_____New York Life	_____Provident Universal Life	_____UNUM Long Term Care
____Employee ____Empl AD&D ____Spouse ____Spouse AD&D ____Children ____Children AD&D	____Employee	____Employee ____Employee Plus One ____Family	____Employee ____Spouse ____Children ____Grandchildren	____Employee ____Employee & Spouse ____Spouse
Deduct Code 014	Deduct Code 025	Deduct Code 007	Deduct Code 112	Deduct Code 124

_____/_____/_____
 Last Name First Middle Birth Date Social Security Number

_____/_____/_____
 Residence Address Male Female Marriage Date

_____/_____/_____
 City State Zip Code Single Married # of Eligible Depend.

(____)_____/_____/_____
 Home Phone Work Phone Department Date Hired

List all eligible dependents to be participants in the plan:

Last Name	First Name	Relationship	Date of Birth	M-Male F-Female	A-Add D-Delete
_____	_____	_____	____/____/____	M F	A D
_____	_____	_____	____/____/____	M F	A D
_____	_____	_____	____/____/____	M F	A D
_____	_____	_____	____/____/____	M F	A D
_____	_____	_____	____/____/____	M F	A D

Change, due to; _____Marriage ____/____/____ _____Death ____/____/____ _____Not Eligible ____/____/____
 _____Divorce ____/____/____ _____Birth ____/____/____ _____Other ____/____/____

I hereby authorize:

_____deductions from my pay for the insurance coverage(s) indicated above	_____Cancellation of my coverage _____/_____/____termination date	For Office Use Only: HRMRep: _____
Employee Signature: _____		Coverage Effective: _____ Change Effective: _____ Total Premium \$ _____