

Instructions: Type or print using ballpoint pen. Return signed original to the Policyholder. A copy should be kept by the employee.

# RELIANCE STANDARD

Life Insurance Company

a DELPHI company

Administrative Office: 2001 Market Street, Suite 1500; Philadelphia, PA 19103

## REQUEST FOR CHANGE

### Employer Section

Policyholder Name \_\_\_\_\_ Location \_\_\_\_\_ Policy No. \_\_\_\_\_

Employee's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_

Employee's Social Security No. \_\_\_\_\_

### Employee Section

**Class Change:** From \_\_\_\_\_ To \_\_\_\_\_

**Name Change:** From \_\_\_\_\_ To \_\_\_\_\_ Marriage Divorce

#### **Smoker/Non-Smoker Status Change:**

(Applies only in connection with Voluntary Group Term Life Insurance)

Employee Spouse (indicate name) \_\_\_\_\_

Have you used any tobacco product, or any product containing tobacco or nicotine, in the last 12 months? Yes No Tobacco/Nicotine-Free From \_\_\_\_\_ To \_\_\_\_\_

#### **Beneficiary Change**

Full Name and Address	% of Proceeds	Relationship	Social Security No.	Birth Date

#### **Dependent Change**

Add	Remove	Name	Birth Date	Relationship	Marriage Date

By completing this Request for Change, I am requesting that a change be made to the information provided on the Enrollment Card/Application. These changes will become effective in accordance with the applicable policy's provisions. This Request for Change will: (a) become a part of the original Enrollment Card/Application; and (b) be subject to the terms of the policy. This signature is to verify: (a) the accuracy of the information contained on this Request for Change; and/or (b) the beneficiary(s) I have designated.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature (Required if smoker/non-smoker status is changing) \_\_\_\_\_ Date \_\_\_\_\_

Effective Date: