

Please retain a copy for insured.



1133 S.W. Topeka Boulevard, Topeka, KS 66629-0001  
Phone in Topeka (785)273-9804, in Kansas (800)530-5989  
Fax (785)290-0727 website: www.advanceinsurance.com

# REQUEST FOR CHANGE

to be completed by the insured

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

Employer HMS Enterprises, Inc, Group number 0023006

Printed name of insured \_\_\_\_\_ S.S. #. \_\_\_\_\_  
(Last) (First) (M.I.)

## Insured name change

From: \_\_\_\_\_  
(Last) (First) (M.I.)

To: \_\_\_\_\_  
(Last) (First) (M.I.)

Due to:  Marriage  Divorce  Other (explain) \_\_\_\_\_ Date \_\_\_\_\_

## Beneficiary change

**\*Primary Beneficiary:**

_____	_____	_____	Relationship	(Age)
(Last)	(First)	(M.I.)		
_____	_____	_____	Relationship	(Age)
(Last)	(First)	(M.I.)		

**\*\*Contingent Beneficiary:**

_____	_____	_____	Relationship	(Age)
(Last)	(First)	(M.I.)		
_____	_____	_____	Relationship	(Age)
(Last)	(First)	(M.I.)		

\* Primary beneficiary will receive the death benefit. If naming two or more beneficiaries, the proceeds will be paid in equal shares unless stated otherwise. If listing a minor child as a beneficiary, the proceeds will be paid to a legal representative appointed by the court system on behalf of the child. If applying for dependent life, it is not necessary to name a beneficiary.

\*\* Contingent beneficiary will receive the death benefit **only** if the primary beneficiary is deceased.

## Dependent life change

Add dependent life benefit ñ effective date \_\_\_\_\_  
Date spouse acquired \_\_\_\_\_ Is spouse employed by above employer?  Yes  No  
Date first child acquired \_\_\_\_\_

Remove dependent life benefit  effective date \_\_\_\_\_

**Note:** Marking this box removes dependent life coverage for all dependents, which includes spouse and **all** eligible children.

## Class change

From class \_\_\_\_\_ To class \_\_\_\_\_ Effective date \_\_\_\_\_

Reason for class change: \_\_\_\_\_

## Authorization ó signatur e and date always required

I hereby apply for amendment of my enrollment as indicated on this form. I understand that I must be actively at work before a benefit can be added. It is mutually agreed that such change shall not become effective unless and until accepted, and that this application for change will become a part of my original application and will be subject to the terms of the master policy.

\_\_\_\_\_  
Authorized signature for group policyholder

\_\_\_\_\_  
Signature of insured

\_\_\_\_\_  
Date