

## Employee Request for Changes

Products and financial services provided by  
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a ONEAMERICA® company  
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This form should be completed for all Employee requests that require an Employee's signature and date. These types of requests include:

- **Change of Address**
- **Name Change** (Due to Marriage or Divorce)
- **Request to Reinstate Coverage**
  - If Employee returns to work within the reinstatement period AND was enrolled in Employee paid coverage prior to leaving employment.
- **Life Event Benefit under Voluntary Term Life contract**
  - Should be completed when an Employee has recently married or had a child and wishes to increase Voluntary Term Life volume.
  - This option is only allowed if elected by the Policyholder and the Employee meets all criteria indicated in the contract.
- **Life Event Benefit under Lump Sum Disability contract**
  - Should be completed when an Employee has recently married or had a child and wishes to add Lump Sum Disability or increase current Lump Sum Disability volume.
  - This option is only allowed if elected by the Policyholder and the Employee meets all criteria indicated in the contract.
- **Request to Add Dependent Coverage**
  - Should be completed when an Employee has recently married and wishes to add the newly eligible Spouse.
  - Should be completed when an Employee has recently acquired a child (birth or adoption) Dependent eligibility must be determined using the contract.
- **Request to Terminate Employee Coverage**
  - This section should be completed when an Employee is still actively at work but wishes to no longer pay for Employee paid coverages. Employees cannot withdraw from Employer paid coverages without submitting a written letter explaining the reason(s) they do not wish to be covered.

The signature page must be signed and dated by the Employee. Signatures by someone other than the Employee will be considered null and void.

**Policyholder and Employee Information (This section must always be completed)**

Policyholder's Name: \_\_\_\_\_ Policyholder's No.: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Insured's Social Security No.: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Section A – Change of Address**

Old Address: \_\_\_\_\_  
*Street Address City State Zip Code*

New Address: \_\_\_\_\_  
*Street Address City State Zip Code*

**Section B – Name Change**

I hereby request my name to be changed from: \_\_\_\_\_  
*First Middle Initial Last*

To: \_\_\_\_\_ Reason for Change: \_\_\_\_\_  
*First Middle Initial Last*

**Section C – Request to Reinstate Coverage**

I hereby wish to reinstate all coverages including all Employee paid coverage I was enrolled in prior to the date of my termination. I understand that all coverages will be reinstated as they were prior to my termination and any increase in coverage will require evidence of insurability.

<b>Employed Full-Time</b>	<b>Authorized to Work and Reside in the U.S.?</b>	<b>Gender</b>	<b>Hours Worked</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	

**Section D – Life Event Benefit under Voluntary Term Life Contract**

I am requesting the additional amount of coverage offered and available without evidence of insurability as a result of a life event, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order.

<b>Full Name</b>	<b>Relationship to Insured</b>	<b>Date of Birth</b>	<b>Date Acquired</b>	<b>Full-Time Student (if 19 or older)</b>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section E – Life Event Benefit under Lump Sum Disability Contract**

I am requesting to add Lump Sum Disability coverage or an additional amount of coverage offered and available without evidence of insurability as a result of a life event, such as marriage or a child's birth, adoption, guardianship, or coverage required pursuant to state law or court order. I will receive the Life Event Benefit amount listed on the Schedule of Benefits for any dependents listed below.

<b>Full Name</b>	<b>Relationship to Insured</b>	<b>Date of Birth</b>	<b>Date Acquired</b>	<b>Full-Time Student (if 19 or older)</b>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

To add dependent coverage due to a life event, complete the next section

**Section F – Request to Add Dependent Coverage**

I hereby request the addition of the coverages selected below for the following dependents:

- Term Life/AD&D     Supplemental Life/AD&D     Voluntary Term Life/AD&D

Full Name		Relationship to Insured	Date of Birth	Gender	Date Acquired	Full-Time Student (if 19 or older)
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No Anticipated Graduation Date _____
Volume/Option	Social Security Number	Reason				
		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court Order (attach a copy) <input type="checkbox"/> Other_____				
Full Name		Relationship to Insured	Date of Birth	Gender	Date Acquired	Full-Time Student (if 19 or older)
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No Anticipated Graduation Date _____
Volume/Option	Social Security Number	Reason				
		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court Order (attach a copy) <input type="checkbox"/> Other_____				
Full Name		Relationship to Insured	Date of Birth	Gender	Date Acquired	Full-Time Student (if 19 or older)
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No Anticipated Graduation Date _____
Volume/Option	Social Security Number	Reason				
		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court Order (attach a copy) <input type="checkbox"/> Other_____				
Full Name		Relationship to Insured	Date of Birth	Gender	Date Acquired	Full-Time Student (if 19 or older)
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No Anticipated Graduation Date _____
Volume/Option	Social Security Number	Reason				
		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court Order (attach a copy) <input type="checkbox"/> Other_____				

**Section G – Request to Terminate Employee Paid Coverage**

I hereby request the termination of the coverages listed below. I understand that any request to terminate Employee coverage automatically terminates any dependent coverage under that contract. I also understand that the actual termination date of coverage will be based on contract details.

				<i>Requested Termination Date</i>
<input type="checkbox"/> Term Life/AD&D	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	_____
<input type="checkbox"/> Supplemental Life/AD&D	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	_____
<input type="checkbox"/> Voluntary Term Life/AD&D	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	_____
<input type="checkbox"/> Short Term Disability				_____
<input type="checkbox"/> Long Term Disability				_____
<input type="checkbox"/> Voluntary Disability	<input type="checkbox"/> Short	<input type="checkbox"/> Medium	<input type="checkbox"/> Long	_____
<input type="checkbox"/> Lump Sum Disability				_____

Reason for withdrawing from Employee Paid coverage:

- Divorce     Age Maximum     Spouse's Group Coverage     No Longer a Dependent  
 Medicare     Other

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

In Michigan: Signature(s) of Dependent Spouse and Child(ren) over age 18: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**Fraud Warnings** (For use in AL, AR, DC, LA, NM, TX and WV)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**Alaska**

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona**

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California**

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or reward payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**Delaware, Idaho, Indiana, Oklahoma**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Kentucky**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee, Washington**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland, Rhode Island**

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire, Ohio**

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

**New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Oregon**

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

**Virginia**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.