Request for Change

EMPLOYEE BENEFITS

ReliaStar Life Insurance Company
P.O. Box 20, Minneapolis, Minnesota 55440

Instructions:

Employee: Complete form and sign as required below.
Return this form to your employer.

Employer: Process the change(s), as necessary.
Place the original in the employee's permanent file.

Insured *(last name, first, middle initial)*		Date of Birth	Social Security #
Plan #	Account #	Policy/Certificate #	

Policy Changes

❐ Change name of _____ Insured ______Owner

Previous name	New name
Reason for change: *(If court order, attach copy)*	

❐ Change address to: *(Include zip code)*

____

❐ Issue duplicate policy/certificate

Coverage Reduction

❐ Reduce employee coverage from $____________ to $____________ effective *(month, day, year)* ____________

❐ Reduce spouse coverage from $____________ to $____________ effective *(month, day, year)* ____________

❐ Reduce children's coverage from $____________ to $____________ effective *(month, day, year)* ____________

Coverage Cancellations

❐ Cancel policy/certificate effective *(month, day, year)* ____________

❐ Cancel spouse coverage effective *(month, day, year)* ____________

❐ Cancel children's coverage effective *(month, day, year)* ____________

Youngest child reached maximum age *(see policy) (month, day, year)* ____________ *(Attach a copy of birth certificate).*

Signature of Employee	Date Signed
Signature of Spouse (if change affecting spouse coverage)	Date Signed
Signature of Employer/Plan Administrator	Date Signed

FOR EMPLOYER/PLAN ADMINISTRATOR USE

Date received	Date processed	Processed by