EMPLOYEE CHANGE REQUEST

Name of Group (Employer) _____ Case Number _____

Your Name (Certificate Holder)_____ Employee Number _____

I.CHANGE OF NAME OR ADDRESS

Your Former Name _____ Your Present Name _____

Date Change Occurred _____

Reason for Change: ☐ Marriage ☐ Divorce ☐ Other _____

Your Former Address _____ Your Present Address _____

_____ _____

II.TERMINATE DEPENDENTS INSURANCE

Name _____ Relation _____ Date of Birth _____

Name _____ Relation _____ Date of Birth _____

(If additional space is needed, please use a separate sheet and attach to this request.)

DATE TO BE TERMINATED _____

REASON FOR CHANGE:

❑ Divorce_____

❑ Other (please explain) _____

III.CHANGE OF CLASS OF INSURANCE

Change from Class _____ to Class_____

Effective (mm/dd/yy) _____ New Monthly Salary $_____

New Job Title_____

Signed by: _____ Date Signed_____

(Authorized Owner, Officer or Partner)

IV.YOUR SIGNATURE

Please Note: This change will be made effective the first of the month following receipt in our office.
I hereby request the Insurance Company to update my insurance records to show the changes set forth above.

Your Signature_____ Date Signed _____

Send This Request to:

Allied National Underwriting Department
P.O. Box 29187
Shawnee Mission, KS 66201-9187
800-825-7531 Fax: 913-945-4397
underwriting@alliednational.com