

LIFE & HEALTH INSURANCE COMPANY



**Employee Request for Change**

**1. Employer Information**

POLICYHOLDER NAME	ADDRESS
POLICY / CASE NO.	PCC/NETWORK ID

**2. Employee Information**

EMPLOYEE NAME	SEX	SOCIAL SECURITY NUMBER
HOME ADDRESS	CITY, STATE, ZIP	<b>Effective Date</b>

**3. Addition of Employee / Dependent Coverage** (Complete Dependent information if adding a dependent for coverage)

Name (First, MI, Last)	Relationship	Sex M-Male F-Female	Date of Birth (mo., day, yr.)	Full-time Student (if age 19 or older)	Social Security Number
	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F			
	Child	<input type="checkbox"/> M <input type="checkbox"/> F			
	Child	<input type="checkbox"/> M <input type="checkbox"/> F			
	Child	<input type="checkbox"/> M <input type="checkbox"/> F			

**4. Termination of Employee/Dependent Coverage** (Complete Dependent information if terminating a dependent for coverage)

Name (First, MI, Last)	Relationship	Sex M-Male F-Female	Date of Birth (mo., day, yr.)	Full-time Student (if age 19 or older)	Social Security Number
	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F			
	Child	<input type="checkbox"/> M <input type="checkbox"/> F			
	Child	<input type="checkbox"/> M <input type="checkbox"/> F			
	Child	<input type="checkbox"/> M <input type="checkbox"/> F			

**5. Employee Authorization**

I hereby request these changes for the insurance for which I am eligible for under the group policy or policies issued to the policyholder by UNICARE Life & Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance.

EMPLOYEE'S SIGNATURE	DATE
----------------------	------