



REQUEST FOR CHANGE
GROUP LIFE, SHORT TERM DISABILITY
AND LONG TERM DISABILITY

Unum Life Insurance Company of America

Please Print or Type — Press Pen Firmly

To The Employee: Complete this form for name changes, changes in coverage for yourself or your dependents or beneficiary changes. If you are adding dependents because of marriage or birth of a child, complete this form within 31 days after the event.

To The Employer: For all changes except beneficiary changes, send this form to Unum Life Insurance Company of America with your next premium payment. For beneficiary changes, keep the completed form in your files. Our claims department will request the most recent beneficiary information if a life insurance claim is filed.

Complete numbers 1 through 5 and 10 for all changes

1. Name of Company | 2. Policy Number | 3. Division Number
4. Employee's Name (Last, First, Middle Initial) | 5. Social Security Number

Complete numbers 6 and 10 if name has changed.

6. Change Employee's Name
From | To | As of (date)

Complete numbers 7 and 10 for changes in employee coverage and numbers 8 and 10 for changes in dependent coverage.

Note: Discontinuance of coverage for the primary insured will result in the discontinuance of coverage for all dependents (spouse/child).

7. Employee Coverage - Check the appropriate statement.
Discontinue the following coverages:
Add the following coverages:

8. Dependent Coverage - Check the appropriate statement.
I decline dependent coverage at this time.
Remove all of my dependents from my plan.
Remove the dependents listed below from my plan as of (date)

Table with 4 columns: Dependent's Full Name, Relationship, Date of Birth (month/day/year), Reason Removed

Add the dependents listed below to my plan as of (date) | Date of marriage (if applicable)

Table with 4 columns: Dependent's Full Name, Relationship, Date of Birth (month/day/year), Reason Added

Complete numbers 9 and 10 to change beneficiaries. To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for assistance. This beneficiary change cancels and supersedes previous designations and may be changed upon written request.

9. As of (date) | beneficiary should be:
Name | Address | Relation

10. Sign below for all changes

X Employee's Signature | Date

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