Underwritten by:
Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

Voluntary Life and Accidental Death and Dismemberment Insurance Change Form
Montana Association of Counties Health Care Trust

Section 1
Employee Information

Must complete this section for all types of changes requested

1

Member Group/ Employer Name:

Employee Name:

Employee ID or SSN:

Employee Address:

Section 2
Beneficiary Change Request

- Beneficiary(ies) Name(s) should be given: e.g. Smith, Mary J./ **not** Smith, Mrs. John J.
- A witness signature must be obtained

All Beneficiary Change Requests are to be maintained for your files.

2

Change my beneficiary(ies) as of:_____

To: Name (Last, First, Middle Initial)	%*	Relationship
If beneficiary(ies) above not living, then pay:		

*Surviving beneficiaries will be paid equally unless otherwise indicated. The change will be effective in accordance with the Group Plan. This beneficiary change cancels and supersedes previous designations and may be changed upon written request.

Witness Signature _____ Date _____

Section 3
Special Enrollment Coverage Request

3

☐ I request that Voluntary Life and Accident Death and Dismemberment Insurance be added under the Group Plan for:

☐ **Spouse**/ Marriage date:_____
Attach completed Voluntary Life and Accidental Death and Dismemberment Insurance Enrollment Form

☐ **Child**/ Birthdate:_____ Life Amount: $10,000 AD&D Amount: $10,000

If requesting spouse and/or dependent child(ren) coverage due to a Special Enrollment Event this form must be received within 31 date after the date of eligibility or coverage cannot be added until the next Annual Open Enrollment Period and Evidence of Insurability will be required.

Section 4
Decrease Amount or Discontinue Coverage Request

Note: Discontinuance of coverage for the employee will result in discontinuance of coverage for spouse and dependent children.

4

Decrease the amount or **Discontinue** coverage for:

Reason_____

Date of Decrease or Discontinuance:_____

Insured	Decrease Life and AD&D Amount To*:	Discontinue Life and AD&D Coverage For:
☐ Self	$	☐
☐ Spouse	$	☐
☐ Child(ren)	$0	☐

*Coverage may only be elected in increments of $10,000. The amount of spouse coverage cannot exceed the amount of employee coverage.

FOR MACOHCT USE ONLY	**COMPLETED BY:**	**NOTES:**
	DATE COMPLETED:	

EMPLOYEE SIGNATURE _____ DATE _____

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