

# Basic Life/Voluntary Life Change Form

Underwritten by: United of Omaha Life Insurance Company



Brought to you by:



**Instructions - Complete and sign below. Return completed form to your Employer.**

**Type of Change**

BASIC LIFE Beneficiary Change -  VOLUNTARY LIFE Beneficiary Change

Both BASIC/SUPPLEMENTAL Beneficiary Change

NAME CHANGE - Previous Name \_\_\_\_\_

**Employer Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (\*).)**

\*Employer's Name: \_\_\_\_\_

District Name: \_\_\_\_\_

District # : \_\_\_\_\_

Group ID: G000ABIH

**Employee Section (Please print clearly. Required fields are marked with an asterisk (\*).)**

\*Last Name \_\_\_\_\_ \*First Name: \_\_\_\_\_ MI: \_\_\_\_\_

\*Social Security Number: \_\_\_\_\_ \*Birth Date (MM/DD/YYYY): \_\_\_\_\_ \*Gender:  Male  Female  
 Marital Status:  Single  Divorced  Married  Widowed

**Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)**

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

**Primary Beneficiary Designation**

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

**Secondary Beneficiary Designation**

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

**Agreement and Signature**

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage.

**SIGNATURE OF EMPLOYEE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_