EMC National Life Company
P.O. Box 9202 ▪ Des Moines, IA 50306-9202 ▪ 1.800.232.5818 ▪ www.EMCNationalLife.com

GROUP DEPARTMENT
FAX: 515-237-2288

REQUEST FOR CHANGE FORM (Group Term Life Plan Only)

Important: Please print legibly.

The following changes are hereby requested in connection with my coverage under Group Policy No. GL 072701

issued to (Group Policyholder): Polk County Government
(Company Name)

My name is_____

1. ☐ CHANGE OF BENEFICIARY

PRIMARY BENEFICIARY(S) Full given name and Social Security Number	ADDRESS OF EACH BENEFICIARY	RELATIONSHIP TO INSURED	DATE OF BIRTH	%
If you name a trust as beneficiary, record name and date of the trust.				
CONTINGENT (SECONDARY) BENEFICIARY(S) Full given name and Social Security Number	**ADDRESS OF EACH BENEFICIARY**	**RELATIONSHIP TO INSURED**	**DATE OF BIRTH**	**%**

If proceeds become payable to two or more beneficiaries of the same class, apportion the proceeds equally among all surviving beneficiaries of that class, unless otherwise stated. If proceeds are not to be equally distributed, please note percentage amount for each beneficiary not to exceed 100%. If none of the above named beneficiaries survive to receive the proceeds, payment shall be made to the "Executor or Administrator of the Insured's Estate."

2. ☐ CHANGE OF NAME

From_____

To _____

3. ☐ CHANGES IN SUPPLEMENTAL EMPLOYEE/MEMBER PAID BENEFITS

Complete a new enrollment form specifying changes. Requests for coverage upgrades are subject to proof of good health.

Unless otherwise specified in the policy, such change or changes requested shall not take effect until the change is approved by the Company and any required premium is paid to the Company.

Dated at _____ this _____ day of _____ , 20 _____
(City, State)

_____
Signature of Employee/Member

Fax or mail a copy to EMC National Life Company at P.O. Box 9206, Des Moines, IA 50306-9206