COVERAGE CHANGE REQUEST

Use this form to make changes to your Unum coverage outside of your company's enrollment period. Changes you can make include updating your name, changing your tobacco status and decreasing or canceling coverage.

How do I fill out this form?

For Employers:

- Complete the form online at: unum.com/esign/CS-1246 (or provide this link to your employee requesting the change)
- Select the changes that you need to make, provide the details we ask for, and sign electronically.
- If you're stuck or need help, please call Ask Unum at 1-800-275-8686.

For Employees:

- Complete it online at unum.com/esign/CS-1246
- If you're stuck or need assistance, please ask your employer for help.

You can't use this form to:

- Enroll in new coverage or add a dependent. (You need to complete an enrollment form to do that.)
- Change a beneficiary. (Please notify your plan administrator to do that.)

I want to: (select)

☐ Change my name ☐ Change my tobacco status ☐ Decrease my coverage amount ☐ Cancel my coverage

Employee Information Please complete this section to begin.

Employer name

ABC Company

Policy number

X

Employee Name (Last, First)

Last name, First name

Social Security Number

000 - 00 - 0000

Change name

Previous name

Last name, First name

New name

Last name, First name

Change tobacco status

Your tobacco use can change the premiums we charge for coverage.

Have you used cigarettes, cigars, snuff, chew, a pipe or any nicotine delivery system in the past 12 months?

☐ Yes ☐ No

Decrease coverage

This decrease is for: (select) ☐ myself ☐ my spouse ☐ my child(ren)

NOTE:
If you decrease coverage for yourself, your spouse or your children, you may need to complete an Evidence of Insurability (Statement of Health) if you decide to re-apply for additional coverage in the future.

Decrease my Life coverage amount to: $

Decrease my AD&D coverage amount to: $

Decrease my Critical Illness coverage amount to: $

Decrease my spouse's Life coverage amount to: $

Decrease my spouse's AD&D coverage amount to: $

Decrease my child(ren)'s Life coverage amount to: $

Decrease my child(ren)'s AD&D coverage amount to: $

Decrease my Accident coverage to lowest level available: ☐ **Yes**

Date you would like decrease to occur:

MM / DD / YYYY

Cancel coverage

This cancellation is for: (select) ☐ **myself** ☐ **my spouse** ☐ **my child(ren)**[1]

NOTE:
If you cancel coverage for yourself, and you carry coverage for your spouse/children on the same policy, their coverage will also be cancelled. If you decide to re-apply for canceled coverage in the future, you may be required to complete an Evidence of Insurability (Statement of Health).

Is the cancellation due to a divorce, death, or a child reaching the age limit on your policy? ☐ Yes ☐ No

If you answered yes to the question above, please enter the date of that event (we will use this date to cancel your coverage). MM / DD / YYYY

Coverage you wish to cancel: (select)


☐ **Life**


☐ **Accidental Death & Dismemberment**


☐ **Long Term Disability**


☐ **Short Term Disability**


☐ **Accident**


☐ **Critical Illness**


☐ **Hospital**


☐ **Dental**


☐ **Vision**

☐ **All**

Sign this form You must sign this form to complete the change process.

Signature **Date**

X _____

1 For Critical Illness benefits: child coverage is included for no additional charge. It can not be changed or canceled.
2 In North Carolina, "Critical Illness" benefits are referred to as "Specified Disease."