



Business Men's Assurance Company of America  
 P.O. Box 419269 / Kansas City, MO 64141

## REQUEST FOR CHANGE

Group Policy No.	Employer, Union or Association Name
Employee's Name	Social Security No.

**1. CHANGE NAME OF EMPLOYEE**

Former Name (Please Print)
New Name (Please Print)
Reason for Change (Correction, marriage, divorce, court order, etc.)

**2. CHANGE OF ADDRESS**

Previous Address
New Address

**3. RECLASSIFICATION OF EMPLOYEE**

The insurance for the person named above will be <input type="checkbox"/> increased <input type="checkbox"/> decreased on the next premium due date following date of change in classification or in accordance with policy provisions.		
Previous Classification, Salary or Benefit Amount	New Classification, Salary or Benefit Amount	Date of Change
Signature of Policyholder Representative _____	Date _____	

**4. CHANGE OF BENEFICIARY**

I hereby request to change the beneficiary under the above numbered policy issued by BMA, with the change to take effect in accordance with the policy provisions as follows:			
	Please print full names and addresses	Relationship	Date of Birth
Primary Beneficiary			
Contingent Beneficiary			

**5. RECLASSIFICATION OF EMPLOYEE AND DEPENDENT COVERAGE**

<input type="checkbox"/> Add the dependents listed below	<input type="checkbox"/> Terminate employee for coverage marked
<input type="checkbox"/> Add all dependents for coverage marked	<input type="checkbox"/> Terminate the dependents listed below for coverage marked
Reason for Change (marriage, divorce, over age, etc.)	Date of Change (marriage, divorce, etc.)
Type of Coverage <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> AD&D <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary AD&D <input type="checkbox"/> LTD <input type="checkbox"/> STD <input type="checkbox"/> Voluntary STD <input type="checkbox"/> Other _____	

	Social Security Number	Benefit Amount	Date of Birth	Sex
Spouse's Name				
Children's Names (indicate if stepchild or foster child) Step and/or foster children must live with the Employee to be eligible				

**SIGN HERE FOR ABOVE REQUEST**

The undersigned requests and agrees to the above changes:	
Employee's Signature _____	Signature of Spouse, if Community Property State _____
Date _____	Date _____

**RETAIN A PHOTOCOPY OF THIS CHANGE FOR YOUR RECORDS**