

PLEASE PRINT

Medical Life Insurance Company

EMPLOYER:

Keep white copy for your records and return only the blue original.

CHANGE REQUEST TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME As it now appears on MLI records

(LAST) _____ (FIRST) _____ (MIDDLE INITIAL) _____

EMPLOYER _____

SOCIAL SECURITY NUMBER _____

MLI GROUP NUMBER _____

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. SEE REVERSE FOR DETAILS.

CHANGE OF BENEFICIARY	First Name	Last Name	Social Security #	Date of Birth	Relationship	Benefit %
Primary				MO / DAY / YEAR		%
Primary				MO / DAY / YEAR		%
Contingent				MO / DAY / YEAR		%
Contingent				MO / DAY / YEAR		%

CHANGE MY NAME TO:

Reason: Marriage Divorce Other _____

EFFECTIVE DATE OF CHANGE: _____

CHANGE DEPENDENT LIFE STATUS:

Add Dependent Life*
 Delete Dependent Life

Reason: Marriage Divorce Other

Date of Marriage: _____
Date: _____
Date: _____

*If previously waived, satisfactory evidence of insurability will be required for **each** dependent.

DATE SIGNED _____

EMPLOYEE'S SIGNATURE: _____

ML9200 R4/97

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (Ohio Revised Code Section 3999.21)