

Request for Change



EMPLOYEE BENEFITS

Reliastar Life Insurance Company
P.O. Box 20, Minneapolis, Minnesota 55440

Instructions:

Employee: Complete form and sign as required below.
Return this form to your employer.

Employer: Process the change(s), as necessary.
Place the original in the employee's permanent file.

Insured (<i>last name, first, middle initial</i>)		Date of Birth	Social Security #
Plan #	Account #	Policy/Certificate #	

Policy Changes

Change name of ____ Insured ____ Owner

Previous name	New name
Reason for change: (<i>If court order, attach copy</i>)	

Change address to: (*Include zip code*)

Issue duplicate policy/certificate

Coverage Reduction

Reduce employee coverage from \$ _____ to \$ _____ effective (*month, day, year*) _____

Reduce spouse coverage from \$ _____ to \$ _____ effective (*month, day, year*) _____

Reduce children's coverage from \$ _____ to \$ _____ effective (*month, day, year*) _____

Coverage Cancellations

Cancel policy/certificate effective (*month, day, year*) _____

Cancel spouse coverage effective (*month, day, year*) _____

Cancel children's coverage effective (*month, day, year*) _____

Youngest child reached maximum age (*see policy*) (*month, day, year*) _____ (*Attach a copy of birth certificate*).

Signature of Insured	Date Signed
Signature of Employer/Plan Administrator	Date Signed

FOR EMPLOYER/PLAN ADMINISTRATOR USE

Date received	Date processed	Processed by
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