



The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
 toll free (800) 423-2765
 www.LFG.com

Please Fax to (877) 573-6177
 Total pages faxed _____

GROUP INSURANCE CHANGE REQUEST

Employer: _____

Policy Number (List all affected policy numbers): _____

Group ID: _____ Insured's Name: _____ Social Security Number: _____

NAME/ADDRESS CHANGE (First-MI-Last):
From:
To:

BENEFICIARY CHANGE	
Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:
NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet of paper.	

DEPENDENTS TO BE ADDED OR REMOVED						
Check One		Name (First-MI-Last)	Date of Birth (Mo. Day Yr.)	Relationship (Spouse or Child)	Date of Marriage (Mo. Day Yr.)	Late Entrant (Yes or No)
Add	Remove					

If adding dependent outside eligibility period, please explain reason:
 For foster or adopted child, show date of placement and any adoption decree.
 NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit it to The Lincoln National Life Insurance Company for review. If dependents are late entrants for Dental coverage, and were previously covered under another plan, please complete the back of this form.

CHANGES IN COVERAGE		
Effective Date of Change: _____	Current Salary: \$ _____	
<input type="checkbox"/> 1. Increase Employee coverage to \$ _____	<input type="checkbox"/> 2. Add/increase spouse coverage to \$ _____	<input type="checkbox"/> 3. Add Dependent Life Coverage \$ _____
Enrollment form must be attached for items 1-3. Evidence of Insurability may be required.		

Effective Date of Change: _____	
<input type="checkbox"/> 1. Reduce Employee coverage to \$ _____	<input type="checkbox"/> 2. Reduce spouse coverage to \$ _____

Date: _____	Insured's Signature: _____	Witness' Signature: _____
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