Change Request Form

Group Premium and Enrollment Services
Underwritten by: United of Omaha Life Insurance Company ● Mutual of Omaha Insurance Company

To Be Completed By Employer Or Plan Sponsor

Employer's Company Name:_ ET Investments, LLC _____City_____State_____Zip_____

Sub-Group Name_____ _____Location Code_____

Group I.D _G000ARSC_____ Sub-Group I.D._____

To Be Completed By Employee (Please Print) Last First M.I.

Social Security Number _____-_____-_____ Name_____ _____ ____

Coverage(s) affected: ☐ Dental ☐ Life/AD&D ☐ Voluntary Life ☐ Long-Term Disability ☐ Short Term Disability

Employee Change(s)

	From	To	Effective Date Mo. Day Yr.
☐ Name[1]	_____	_____	____/____/____
☐ Salary	_____	_____	____/____/____
☐ Sub-Group	_____	_____	____/____/____
☐ Class[1]	_____	_____	____/____/____
☐ Address	_____ Address	_____ Zip Code	
	_____ City	_____ State	____/____/____

[1]Reason: _____

Terminate Insurance: **Effective Date** Mo. Day Yr.

Reason (specify)_____ ____/____/____

_____

Reinstatement of Insurance: **Effective Date** Mo. Day Yr.

Date Returned to Work ____/____/____

Date Previously Canceled[2] ____/____/____

[2]Reason for Previously Cancellation: (check one)

☐ Layoff
☐ Disability
☐ Leave of Absence
☐ Other (specify) _____

Dependent Event Change(s) (Both Event Reason And Date Of Event Must Be Completed)

Event Reason: ☐ Marriage ☐ Birth ☐ Adoption ☐ Step-child(ren)[3] ☐ Divorce ☐ Death

☐ Loss of Coverage (must specify reason) _____

☐ Other (must specify reason) _____

Date of Event: _____/_____/_____ **Amount of Life Volume for new dependent(s):** Spouse $_____ Child(ren) $_____

Change Life Volume: Employee from $ _____ to $ _____ ; Spouse from $_____ to $_____; Child(ren) from $_____ to $_____

ADD	DELETE	Name of Dependents	Sex	Relationship	Birthdate Mo. Day Yr.	Social Security No.
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Indicate ALL Dependent(s) Covered AFTER Change(s) above is (are) Made: (check one only)

☐ Spouse ☐ Child ☐ Children ☐ Spouse and Child(ren) ☐ No Dependent Coverage

See your benefits administrator for the required form(s):
If the dependent(s) listed is not your natural child, please complete the Statement of Responsibility for a Dependent Child form and submit with this enrollment form.
If dependent is 19 years of age or older (unless otherwise stated in the plan) and a full-time student, complete a Student Dependent Attendance Report form and submit with this enrollment form.

Other Insurance

Do you or any of your dependents have coverage under **any other Dental plan** that you will retain **after** enrolling in this health plan? ☐ Yes ☐ No

If yes, please provide the following information about your/their other insurance coverage:

Primary Covered Individual	Who is covered? (i.e. employee, spouse, dependent's name)	Name of Employer offering Other Insurance	Other Insurance Company Name	Policy Number	Effective Date

INSURANCE COMPANY USE ONLY

_____/_____/_____
Effective Date Of Change

Instructions: If you want to add a new dependent to this plan, you must make written request for dependent coverage by completing this Change Request Form. You must return this form to your plan administrator. To add an eligible dependent you must make your written request within 31 days (or as otherwise stated in the plan) after such dependent becomes eligible under the terms of this group plan. If your written request is made after 31 days, your eligible dependent may be considered a late enrollee and may be subject to additional conditions as stated in the plan. If the plan is contributory, this form **must** be signed and dated to authorize payroll deductions.

I represent that the information I have provided in this Change Request Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee _____**Date** ____/____/____