Group Administration Card

EMPLOYEE'S NAME ***(PLEASE PRINT)***______________________________________

EMPLOYER________________________________ **POLICY NUMBER**____________

A. **WAIVER/TERMINATION OF GROUP INSURANCE COVERAGE:** I certify that I have been given an opportunity to apply for the Group Insurance benefits checked below, I understand fully the benefits of the plan, and decline/request termination of the coverage. I understand that any current insurance will terminate at the end of the period of the last premium payment.

- ☐ **Basic Group Life**
  - ☐ Myself Only
  - ☐ My Dependents Only
  - ☐ Myself & My Dependents
- ☐ **Additional Group Life**
  - ☐ Myself Only
  - ☐ My Spouse Only
  - ☐ My Children Only
  - ☐ Myself, Spouse & Dependents
- ☐ **Group Short Term Disability**
- ☐ **Group Long Term Disability**
- ☐ **Group Vision**
  - ☐ My Dependents Only

B. **REQUEST FOR REDUCTION IN GROUP INSURANCE COVERAGE:** I request that my benefit be reduced as listed below. I understand that the reduced benefit will be effective on the first day of the month following the date this request form is signed.

Benefit	From	To
☐ **Additional Group Life**		
☐ Myself Only	$ ________	$ ________
☐ My Spouse Only	$ ________	$ ________
☐ **Short Term Disability**	$ ________	$ ________

Sign here for item A & B**: I understand that if I wish to apply for this insurance at a later date, satisfactory Evidence of Insurability will be required at my own expense.**

__________ Date ______________ Signature of Employee

C. **REQUEST FOR CHANGE OF BENEFICIARY:** I hereby designate the person or persons named below as beneficiary, revoking any other beneficiary designation, such change to be effective according to the terms and conditions of the group policy. Unless otherwise provided herein, beneficiaries designated to share proceeds shall share equally and the share of a beneficiary who does not survive me shall be paid to the surviving beneficiary. If no beneficiary survives me, payment shall be made according to the terms of the Policy, subject to revocation by me by written notice to my employer.

PRIMARY BENEFICIARY'S LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO YOU
FULL ADDRESS OF BENEFICIARY			PHONE
CONTINGENT **BENEFICIARY'S** LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO YOU
FULL ADDRESS OF BENEFICIARY			PHONE

D. **REPORT OF CHANGE OF NAME:** I hereby request that the records kept in connection with the Group Policy reflect the following change of name: ☐ Insured Person ☐ Beneficiary

________ Date of Change ________ From ________ To

E. **REQUEST FOR ADDITION OF DEPENDENTS:** I hereby apply for Dependent Life insurance on all of my dependents who are now eligible as defined in the Group Policy and any dependents who may hereafter become eligible, subject to revocation by me by written notice to my employer. I authorize the required deduction (if any) from my wages.

________ Date of Marriage ________ Spouse's Name ________ Number of Eligible Children

Sign here for item C, D, & E:

________ Date ________ Signature of Employee

________ Date ________ Witness

Recorded on behalf of the Company subject to the terms and conditions of the Group Policy.

________ Date ________ By

Administration Card
Form 60-06 (Rev. 1/2000)

Return all copies to **- UNITED HERITAGE** Life Insurance Company
P.O. Box 7777 - MERIDIAN, IDAHO 83680-7777