



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate®

Request for Change Form

Workplace Division

Please Print Clearly

EMPLOYER NAME				GROUP NUMBER	
EMPLOYEE'S NAME Last (Sr, Jr, etc)		First		M.I.	
SOCIAL SECURITY NUMBER OR CERTIFICATE NUMBER					
<input type="checkbox"/> CHANGE NAME <input type="checkbox"/> Employee <input type="checkbox"/> Dependent If a dependent, complete the information below:					
			Relationship		Social Security Number
Change Name From: _____ To: _____					
Please Provide the Reason for the Change: _____					
<input type="checkbox"/> CHANGE ADDRESS <input type="checkbox"/> Employee <input type="checkbox"/> Dependent - Name of Dependent: _____					
To: _____					
STREET or P.O. BOX		CITY		STATE	ZIP
<input type="checkbox"/> CHANGE OF BENEFICIARY: I hereby request, subject to the terms of the Group Policy whose Group number is indicated above, that the beneficiary for the Life Insurance or Accidental Death and Dismemberment Insurance, if any, provided under such Group Policy be changed as shown below. Any beneficiary designation and/or settlement designations previously made is hereby revoked.					
PRIMARY BENEFICIARY (To receive Proceeds if living at the Insured employee's death)					
COMPLETE NAME OF PRIMARY BENEFICIARY			RELATIONSHIP TO INSURED EMPLOYEE		
CONTINGENT BENEFICIARY (To receive Proceeds if living at the Insured employee's death and if Primary Beneficiary is not living)					
COMPLETE NAME OF CONTINGENT BENEFICIARY			RELATIONSHIP TO INSURED EMPLOYEE		
<input type="checkbox"/> ADD COVERAGE for Dependent(s), as requested on the fully completed Dependent Enrollment Form attached.					
<input type="checkbox"/> TERMINATE COVERAGE as indicated below:					
TYPE OF COVERAGE: 1. MEDICAL 2. DENTAL 3. CANCER 4. ACCIDENT 5. HOSPITAL INDEMNITY 6. CRITICAL ILLNESS					
RELEVANT PERSON	NAME	SOCIAL SECURITY NUMBER	TYPE OF COVERAGE	REASON FOR TERMINATION	DATE OF TERMINATION
EMPLOYEE					
SPOUSE					
DEP. CHILD					
DEP. CHILD					
DEP. CHILD					
Medical Coverage Only: I understand that if I am terminating the group health coverage for me or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to re-enroll myself or my dependents in this health plan, provided that I request enrollment within 30 days after the other coverage ends.					
All Coverages: If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll all of my dependents for health coverage, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.					

Date Signed _____

Employee's Signature _____