Request for Service Life Change Form
Group Universal Life Insurance (GUL)

Cigna Customer Service Center
Administered by Infosys McCamish Systems, LLC
PO Box 14577
Des Moines, IA 50306-3577
1.800.828.3485
Facsimile 1.877.435.7181
Collect 515.243.1776 from
Alaska or Outside the U.S.A.

CLEAR FORM

Last Name	First Name	Middle Initial	Certificate No.
Mailing Address			Residence Telephone #
City	State	Zip Code	Employer Name
Social Security #	Date of Birth	Sex ◯ Male ◯ Female	Daytime Telephone #

ABOVE SECTIONS MUST BE FULLY COMPLETED

☐ A. Name change of: ◯ Insured ◯ Owner / Certificate Holder ◯ Other _____

From: (*First, Middle, Last*)

To: (*First, Middle, Last*)

Reason for Change:

☐ * B. Change the amount of insurance coverage to $ _____

☐ * C. Add / Cancel coverage for my dependent children in the amount of $ _____ ◯ Add ◯ Cancel

If cancel - is this your last dependent child? ◯ Yes ◯ No * Medical Information may be required

Name	Birthdate	◯ Add	◯ Cancel
Name	Birthdate	◯ Add	◯ Cancel

☐ D. My dependent child is no longer eligible for coverage as of the following date *(Mo., Day, Yr.)*: _____
Please send rates and enrollment information for a separate certificate for that child.

☐ E. Change the monthly contribution to my Cash Accumulation Fund.

Employee ◯ Increase ◯ Decrease New Amount $ _____

Spouse ◯ Increase ◯ Decrease New Amount $ _____

☐ F. Add a lump sum contribution to my Cash Accumulation Fund *(Check enclosed)* Amount: $ _____

(Please note all lump sum contributions are subject to a state premium tax and IRS Guidelines)

☐ * G. Add/Cancel the Accelerated Payment Benefit ** ◯ Add ◯ Cancel * Medical Information may be required

☐ * H. Add/Cancel the Automatic Increase Option ** ◯ Add ◯ Cancel **Please refer to Coverage Option Page of enrollment booklet if an applicable benefit.

☐ * I. Add/Cancel the Accident Death Benefit ** ◯ Add ◯ Cancel

☐ J. Change my address to: _____

_____

☐ K. I am terminating my employment and wish to be billed at my home.

☐ L. I wish to: _____

☐ * M. I want to change my coverage due to a Life Status Change. The Life Status Change is: _____

Date of event: _____ Type of change requested: _____

I authorize the above changes to my Group Universal Life coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to make the appropriate payroll deductions for changes noted above. *(Does not apply to those being billed at their home)* .

Owner's Signature: _____ Date: *(Mo., Day, Yr.)*: _____

Group Universal Life Insurance policies are underwritten by Connecticut General Life Insurance Company and Life Insurance Company of North America, Cigna companies.

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