VOLUNTARY LIFE COVERAGE CHANGE REQUEST

Use this form to make changes to your voluntary life insurance coverage outside of a regular enrollment period. Changes you can make include updating your name, decreasing or canceling coverage.

Please complete all sections corresponding to your coverage change request.

Return the signed form to Attn: Cineca Anthony

Mail to: Reformed Church in America
475 Riverside Drive, Suite 1606
New York, NY 10115

Fax: 833-627-7620

Email: retirement@rca.org

You can't use this form to:

- Enroll in new coverage or add a dependent. (You need to complete an enrollment form to do that.)

I want to: (select)

☐ Change my name ☐ Decrease my coverage amount ☐ Cancel my coverage

Employee information: Please complete this section to begin.

Employer name

Board of Benefits Services of the Reformed Church in America

Group ID/Policy #

973428 1694599

Employee name (Last, First)

Social Security Number

Change name:

Previous name (Last, First)

New name (Last, First)

Decrease coverage:

This decrease is for: (select) ☐ **myself** ☐ **my spouse** ☐ **my child(ren)**

NOTE:
If you decrease coverage for yourself, your spouse or your child(ren), you may need to complete an Evidence of Insurability (Statement of Health) if you decide to re-apply for coverage in the future.

Date you would like decrease to occur:

MM / DD / YYYY

Decrease my Life coverage amount to: $

Decrease my AD&D coverage amount to: $

Decrease my Critical Illness coverage amount to: $ N/A

Decrease my spouse's Life coverage amount to: $

Decrease my spouse's AD&D coverage amount to: $

Decrease my child(ren)'s Life coverage amount to: $

Decrease my child(ren)'s AD&D coverage amount to: $

Cancel coverage:

This cancellation is for: (select) ☐ **myself** ☐ **my spouse** ☐ **my child(ren)**[1]

NOTE:
If you cancel coverage for yourself, and you carry coverage for your spouse/child(ren) on the same policy, their coverage will also be cancelled. If you decide to re-apply for coverage in the future, you may be required to complete an Evidence of Insurability (Statement of Health).

Is the cancellation due to a divorce, death or a child reaching the age limit on your policy? ☐ **Yes** ☐ **No**

If you answered yes to the question above, please enter the date of that event (we will use this date to cancel your coverage).

MM / DD / YYYY

Coverage you wish to cancel: (select)

☐ Life

☐ Accidental Death & Dismemberment

Sign this form: You must sign this form to complete the change process.

Signature X

Date