GROUP VOLUNTARY LIFE INSURANCE CHANGE FORM

SEANC INSURANCE DEPARTMENT
P O Drawer 27727
Raleigh, NC 27611-7727

For SEANC use only
Premium $_____
Effective Date:_____
Payroll _____

THIS FORM IS FOR CHANGES IN INSURANCE ONLY

PLEASE FILL IN NAME AND SOCIAL SECURITY # ON ALL CHANGE FORMS.
COMPLETE ONLY THE SECTION(S) IN WHICH CHANGE OCCURS. (i.e., address, beneficiary, dependent coverage)

Group #: 40138	Policyholder STATE EMPLOYEES ASSOCIATION OF NORTH CAROLINA	Department/Agency
Social Security # - -	Member Name *(Last, First, Middle initial) as it currently appears on file*	
	Member New Name *(Last, First, Middle initial)*	
	Member New Address *(Street, City, State, Zip)*	
	Occupation	Avg. Hours Worked
Home Telephone Number ( )	Work Telephone Number ( )	

Insurance Coverage: Current Coverage Amount $_____ New Selected Coverage Amount $_____

Beneficiary Information

	Name of Beneficiary	Relationship	Benefit %
Primary			
Primary			
Contingent Beneficiary			
Contingent Beneficiary			

If more than one beneficiary is designated, the proceeds will be split equally unless otherwise indicated.

Information: Spouse/Dependent Child(ren)

Spouse Life Insurance Yes ☐ No ☐ Dependent Child(ren) Life Insurance Yes ☐ No ☐
Spouse's Name: _____
Spouse's Date of Birth: _____ The beneficiary for the spouse and dependent children is the member.

I authorize SEANC Insurance to make the above change(s) to my current Boston Mutual Group Voluntary Life Insurance policy.

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the group policy or group policies issued to SEANC by the Boston Mutual Life Insurance Company and authorize deductions from my earnings of the required premium contribution toward thecost of the insurance.

I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.

I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Member: _____ Date: _____