Group number: _____

Disability Change Form

Instructions: Please complete boxes outlined in **RED**

A: Personal Information

Last Name: Middle Initial: First Name:
Date of Birth: __/__/____ Social Security Number:
Street Address: Apt #:
City: State: Zip Code:
Home Phone Number: E-mail Address:
Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed
Gender: ◯ Male ◯ Female

B: Type of Change [MUST SELECT OPTION(S)]

☐ **Name Change:**
Previous Name:
New Name:

☐ **Address Change:**
Previous Address:

New Address:

☐ **Cancel Current Disability Coverage***
Cancellation Date: _____/_____/_____

*Subjected to contracted date – coverage may extend to last day of month

C: Acknowledgement of Coverage and Signature

Name Printed:

Signature: Signature Date: __/__/____