Complete This Form and Return To:
Selman & Company
Attn: Customer Service Dept.
6110 Parkland Boulevard
Cleveland, OH 44124-4187
Phone: 877.665.7563

Request for Change In Group Accidental Death & Dismemberment (AD&D) Insurance from:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

1. INSURED MEMBER INFORMATION:

_____
Last Name First Middle Initial

_____
Home Address: Street City State Zip Code

_____ (_____) _____ -_____ _____/_____/_____ _____
Insured ID Number Home Phone Number (w/area code) Date of Birth (mm/dd/yy) Sex (M/F)

Financial Institution Name: _____

Financial Institution Account Number: _____ ❑ Checking ❑ Savings

2. INSURANCE REQUESTED (If adding/increasing coverage, refer to the brochure for eligibility, options and coverage description.)

I hereby apply to add/increase/decrease/terminate my coverage as noted:

❑ **Increase.** I currently have $_____ of AD&D Insurance and wish to INCREASE this amount to $_____. *(Coverage is available in units of $5,000.) The **maximum** amount of Voluntary coverage is $300,000. I understand that there will be an increase in premium. (Note: If Adding Dependent Coverage, the beneficiary will be the same as the one currently on record for Customer. To designate a new beneficiary, contact the Administrator for the necessary form.)*

❑ **Add Dependents**. I currently have the Individual Plan and wish to CHANGE TO the FAMILY PLAN wherein my eligible dependents would be covered.

❑ **Decrease.** I currently have $_____ of AD&D Insurance and wish to DECREASE this amount to $_____. *(Coverage is available in units of $5,000.) The **minimum** amount of Voluntary coverage is $10,000.*

❑ **Decrease.** I currently have the Family Plan and wish to CHANGE TO the INDIVIDUAL PLAN, wherein only I will be covered.

❑ **Terminate.** I currently have $_____ of AD&D Insurance and wish to TERMINATE my:
❑ Voluntary Insurance ❑ Voluntary Insurance, and Basic Insurance paid for by my Financial Institution.

3. ADMINISTRATIVE CHANGES:

❑ **Premium Deduction Account Change**. Please change the account from which premiums are deducted to the following:
Account #_____ ❑ Checking ❑ Savings

❑ **Address change**. Please change my home address to the following:

_____
Street City State Zip Code

❑ **Name change**. Please change my name. *(Note: A copy of your driver's license, marriage certificate, divorce decree, birth certificate or other legal document verifying the change <u>MUST</u> be included with your request.)*
From:_____To:_____

I request the group insurance AND/OR change(s) shown above. If adding or increasing coverage, I understand the conditions and exclusions of the Policy, as stated in my Certificate of Insurance. New coverage begins on the Effective Date, provided the first premium is paid when due.

Insured Member's Signature X_____ _____
(PLEASE SIGN IN INK) **DATE**