Certificate No. ______________________ -05

Request For Change Form
Long-Term Disability Insurance

Name of Insured ____

Social Security No. ____

I hereby request that the benefit amount for my coverage be changed to ________________ .

Please make this change effective ______________________ , or as soon thereafter as possible.

I understand that when I choose to increase my benefit level, a new preexisting conditions limitations period will apply on the increase.

______________________ ____

Date Signature in ink

NOTICE OF PREEXISTING CONDITIONS LIMITATIONS:
Coverage is issued with a preexisting conditions limitation. If you have received treatment for a medical condition within the 6 months immediately preceding the date your coverage is effective, then you must satisfy one of the following: (1) go 6 months free of treatment on or after your effective date; or (2) be insured for 12 months even with treatment. **This preexisting conditions limitation does not apply to any other cause of disability.**

FOR P&B OFFICE USE ONLY

Received ______________________ Effective Date ______________________

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