



**Fax To:**  
(870)779-9138

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**Mail To:**  
Southwest Region-Texarkana  
P.O. Box 2018  
Texarkana, AR 75504-2018

**CHANGE REQUEST FORM**

First Name	M.I.	Last Name
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Employee ID No.	Date of Birth	SSN
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Home Address: \_\_\_\_\_

**Current Coverage Information**  
Employer Name \_\_\_\_\_ Group No. \_\_\_\_\_

**Cancel Contract\***  
Date Last Worked \_\_\_\_\_ Date of Cancellation: \_\_\_\_\_  
Reason \_\_\_\_\_

*\* For maximum credit, this form must be received by the Company **before** the end of the billing period in which the termination occurred. Failure to provide notice of termination timely will result in additional premiums due.*

**Change Coverage (as indicated below)**

Name Change  
Former Name \_\_\_\_\_ New Name \_\_\_\_\_

Address Change  
New Address \_\_\_\_\_ Phone \_\_\_\_\_

Terminate a Family Member(s) Coverage  
Name(s) \_\_\_\_\_  
Reason  Divorce  Death  Other \_\_\_\_\_ Date of Event \_\_\_\_\_

Beneficiary Change  
I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	M.I.	Last Name	Date of Birth	Relationship

Other \_\_\_\_\_

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Group Administrator

\_\_\_\_\_  
Date