



Employee Change Request

GE Group Life Assurance Company
100 Bright Meadow Boulevard
PO Box 1955
Enfield, CT 06083-1955

Name of Firm	Firm's State	Account Number 1	Account Number 2
Name of Employee		Social Security Number	Date of Change

CHANGE OF COVERAGE

PLEASE NOTE: If you refuse any coverage now and at a later date request to add that coverage, you may have to furnish at your own expense, evidence of insurability satisfactory to GE Group Life Assurance Company for each person to be covered.

ELECTION OF COVERAGE / REFUSAL OF COVERAGE

I ELECT <input type="checkbox"/>	I REFUSE <input type="checkbox"/>	Basic Life	I ELECT <input type="checkbox"/>	I REFUSE <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Medical Coverage for Myself <input type="checkbox"/> PPO/Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	Medical Coverage for My Eligible Dependents. Are any dependents still insured? <input type="checkbox"/> No <input type="checkbox"/> Yes How many? _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental Coverage for Myself <input type="checkbox"/> DHMO <input type="checkbox"/> PPO/Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	Dental Coverage for My Eligible Dependents. Are any dependents still insured? <input type="checkbox"/> No <input type="checkbox"/> Yes How many? _____
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life Coverage	<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life Coverage for My Eligible Dependents. Number of Dependents _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Life - Please complete the appropriate enrollment and request form: ESG-GL2320			

Reason _____ . If due to marriage or birth of a child, please supply date(s) _____

My current salary is \$ _____ per _____ (Basic earnings, excluding overtime)

Employee's Signature	Date Signed
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Did you or your Dependent have prior coverage? Yes No If "yes", Single Family Dependent

Individual Policy Group Policy HMO Other _____

Name of Carrier _____

Termination Date of Coverage ____ / ____ / ____ Reason for Termination _____

CLASS CHANGE/TRANSFER

Transfer From Account _____ to _____ Effective Date _____

Class Change From _____ to _____ Effective Date _____

Please Check Reasons:

New Occupation (State New Occupation) _____ Salary \$ _____

Retirement Other _____

When reporting Terminations, Salary Changes or Name Changes call toll free 1-800-451-2513 or complete the appropriate section(s) below.

TERMINATION

Last Day of Employment (MM/DD/YY)	Reason	Election of Continuance (Please attach form)
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SALARY CHANGE

Effective Date (MM/DD/YY)	Basic Earnings \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours Worked Per Week (Excluding overtime)
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NAME CHANGE

Date of Change	New Name	Previous Name	Reason	Date Received
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Address Change (Employee's Address, Number, Street, City, State, ZIP Code):

State Law, in some states, requires the following:

Any person who knowingly and with intent to defraud any insurance company or other person either:
1) files an application for insurance or statement of claim containing any materially false information, or
2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES. In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICES CONCERNING MEDICAL COVERAGE:

PRE-EXISTING CONDITIONS (not applicable to pregnancy). The Medical Plan contains a pre-existing condition limitation that may apply to you and/or your dependents. Any applicable pre-existing condition limitation will be reduced by your prior creditable coverage, if any. You have the right to request a certificate of creditable coverage from your prior health plan and we will assist you in obtaining this certificate, if necessary. For additional information regarding the plan's pre-existing condition limitation, please see your plan administrator.

SPECIAL ENROLLMENT RIGHTS. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in this medical plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption or placement for adoption.