



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Credit Union Name: \_\_\_\_\_

City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Account Number: \_\_\_\_\_

G05998-0

**CHANGE FORM**

**AFFINITYLIFE Group Term Life**

**Insurance**

**1 Please Decrease Amount of Supplemental Coverage To:**

Insured	Spouse		Insured	Spouse		Insured	Spouse	
<input type="checkbox"/>	<input type="checkbox"/>	\$25,000	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	<input type="checkbox"/>	<input type="checkbox"/>	\$175,000
<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	<input type="checkbox"/>	<input type="checkbox"/>	\$125,000	<input type="checkbox"/>	<input type="checkbox"/>	\$200,000
<input type="checkbox"/>	<input type="checkbox"/>	\$75,000	<input type="checkbox"/>	<input type="checkbox"/>	\$150,000	<input type="checkbox"/>	<input type="checkbox"/>	Other Amount \$ _____

(Specify amount from \$25,000 to \$250,000 in \$5,000 increments)

**To Increase Your Coverage Please Contact LifeHelp at (1-800-345-4543)**

**2 I Want to Change: (Check Appropriate Box)**

- Cancel Primary Basic Coverage *(Cancels ALL coverage)*
- Cancel Spouse Basic Coverage *(Cancels Spouse coverage only)*
- Turn off Inflation Guard *(cannot be restarted)*
- Cancel Primary Supplemental Coverage *(Primary Basic coverage remains in effect)*
- Cancel Spouse Supplemental Coverage *(Spouse Basic coverage remains in effect)*
- Cancel Child Coverage *(Cancels Child coverage only)*
- Add Child Coverage

**Reason for Cancellation:**

- Primary Member Deceased
- Closed account
- Billing Information Was Not Clear
- Spouse Deceased
- Duplicate Coverage
- Other: \_\_\_\_\_
- Rates Too High
- No Longer Need Life Insurance

**3 Change my Name, Account Number, or Address:**

**Name** From: \_\_\_\_\_ To: \_\_\_\_\_

**Address** From: \_\_\_\_\_ To: \_\_\_\_\_

**Account Number** From: \_\_\_\_\_ To: \_\_\_\_\_

Checking  Savings

Checking  Savings

**Member's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please retain a copy of this form for your records.

**For Office Use Only**

The requested change has been completed and recorded on behalf of New York Life. This copy is being returned for your files.

By: \_\_\_\_\_ Date: \_\_\_\_\_