



Lincoln Mutual Life and Casualty
 4510 13th Avenue South • P.O. Box 1918 • Fargo, North Dakota 58107-1918
 Toll-free 1-800-233-6050 • www.lml.com

REQUEST FOR SERVICE

Insured Employee

Mail to above address.

<i>(Type or Print)</i>		State	Group Number	Division
Employer's Name _____		Group Number		
Employer's Address _____				
Street		City	State	Zip Code
Telephone Number _____		Correspondence to: _____		
Area Code		Number		
<i>Please check boxes below for desired action and provide requested information, if any.</i>				
<input type="checkbox"/> Termination of Insured Employee	Name of Employee _____	Certificate # _____	Termination Date _____	
	Name of Employee _____	Soc. Sec. # _____	Termination Date _____	
	Signature of Company Representative _____		Date _____	
<input type="checkbox"/> Addition of Dependent Coverage	I hereby apply for Dependents Group Insurance Coverage for which I am or may become eligible under the Group Insurance Contract issued to my Employer and authorize the deduction from my earnings (if contributory) of the amount required to cover my share of the premiums. Unless dependents are newly acquired (e.g. newborn or through marriage), and we are not notified within 31 days of their acquisitions, they are considered late entrants, and evidence of insurability is required. Coverage will be effective the first of the month following approval.			
Names of ALL Eligible Dependents				
Last	First	Relationship	Date Acquired*	
_____	_____	_____	_____	
_____	_____	_____	_____	
Signature of Insured Employee Requesting Change _____ Soc. Sec. # _____ - - _____ Date _____				
*(1) For an Eligible Spouse – give date of marriage. (2) For Adopted Children – give date of legal adoption. (3) For Step-Children acquired by marriage – give date of marriage. (4) For your other children – give their dates of birth.				
<input type="checkbox"/> Termination of Dependent Coverage	I no longer wish coverage on my dependents and request single coverage effective <i>(effective first of the month following receipt of the request)</i>			
Signature of Insured Employee Terminating Dependent Coverage _____ Soc. Sec. # _____ - - _____ Date _____				
<input type="checkbox"/> Insured Employee Name Change	From _____ To _____			
Signature of Insured Employee Requesting Name Change _____ Soc. Sec. # _____ - - _____ Date _____				
<input type="checkbox"/> Insured Employee Address Change	Name _____			
	Address _____			
	Street	City	State	Zip Code
Signature of Company Representative _____ Date _____				
<input type="checkbox"/> Class Change	Name of Employee _____	Soc. Sec. # _____	Effective Date _____	
	Name of Employee _____	Soc. Sec. # _____	Effective Date _____	
	Signature of Company Representative _____		Date _____	
<input type="checkbox"/> Salary Change	Name of Employee _____	Soc. Sec. # _____	Effective Date _____	
	Name of Employee _____	Soc. Sec. # _____	Effective Date _____	
	Signature of Company Representative _____		Date _____	
<input type="checkbox"/> Other	_____			Date _____