



Group Name \_\_\_\_\_

# Policyholder Change to be Completed by Employer

Group Number \_\_\_\_\_

Administrative Offices: Downers Grove, Illinois | Dallas, Texas

## Employer: Please fax this form to: (312) 240-0143

For best results, use a black felt-tip pen and block-style lettering, to complete.

Do NOT mail enrollment card to FDL. Keep in employee file.

ACTION	SSN	Effective Date of Change			Date of Hire			New Salary						
	— <input type="checkbox"/>	____-____-____	____/____/____	____/____/____	____/____/____	____,____.____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually					
Name (Complete Name field if changing name or adding an employee.)														
LAST				FIRST				M.I.			Gender			
____				____				____			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Birth Date			Benefit Class		Basic Life & AD&D		STD Benefit		LTD Benefit		Supplemental Life/Amt		Supplemental AD&D/Amt	
____/____/____			____		<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Add <input type="checkbox"/> Remove		\$____,000		<input type="checkbox"/> Add <input type="checkbox"/> Remove \$____,000	

Dependent Life	Dependent Change Reason	<input type="checkbox"/> Marital Status
<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Other
<input type="checkbox"/> Remove		

ACTION	SSN	Effective Date of Change			Date of Hire			New Salary						
	— <input type="checkbox"/>	____-____-____	____/____/____	____/____/____	____/____/____	____,____.____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually					
Name (Complete Name field if changing name or adding an employee.)														
LAST				FIRST				M.I.			Gender			
____				____				____			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Birth Date			Benefit Class		Basic Life & AD&D		STD Benefit		LTD Benefit		Supplemental Life/Amt		Supplemental AD&D/Amt	
____/____/____			____		<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Add <input type="checkbox"/> Remove		\$____,000		<input type="checkbox"/> Add <input type="checkbox"/> Remove \$____,000	

Dependent Life	Dependent Change Reason	<input type="checkbox"/> Marital Status
<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Other
<input type="checkbox"/> Remove		

ACTION	SSN	Effective Date of Change			Date of Hire			New Salary						
	— <input type="checkbox"/>	____-____-____	____/____/____	____/____/____	____/____/____	____,____.____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually					
Name (Complete Name field if changing name or adding an employee.)														
LAST				FIRST				M.I.			Gender			
____				____				____			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Birth Date			Benefit Class		Basic Life & AD&D		STD Benefit		LTD Benefit		Supplemental Life/Amt		Supplemental AD&D/Amt	
____/____/____			____		<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Add <input type="checkbox"/> Remove		\$____,000		<input type="checkbox"/> Add <input type="checkbox"/> Remove \$____,000	

Dependent Life	Dependent Change Reason	<input type="checkbox"/> Marital Status
<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Other
<input type="checkbox"/> Remove		

### ACTION CODE

- |                        |                       |
|------------------------|-----------------------|
| 1. ADD EMPLOYEE        | 5. CHANGE OF BENEFIT  |
| 2. NAME CHANGE         | 6. REMOVE BENEFIT     |
| 3. SALARY CHANGE       | 7. TERMINATE EMPLOYEE |
| 4. ADDITION OF BENEFIT | 8. REINSTATE EMPLOYEE |

If your plan requires Evidence of Insurability, please submit an Evidence of Insurability form.

If your employees wish to apply or make changes to Voluntary coverages, please FAX a copy of the completed enrollment form to the number shown above.