

Company name \_\_\_\_\_ Group/unit number \_\_\_\_\_

**Employee Information** (Change of name and address)

Your name (last, first) \_\_\_\_\_ Social security number \_\_\_\_\_

New name (last, first) \_\_\_\_\_

New address\* (street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

\*New address information is only needed if you have medical, dental or vision.

**Complete for Adding, Canceling or Changing\* a Coverage**

<b>Medical</b>	add	employee	spouse	children	Medical options (if applicable to your group policy): Deductible: _____ PPO Network: _____
	cancel	employee	spouse	children	
	change to: _____				
<b>Dental</b>	add	employee	spouse	children	<b>Short Term</b> add _____ cancel _____ <b>Disability</b> occupation: _____
	cancel	employee	spouse	children	
	change to: _____				
<b>Vision</b>	add	employee	spouse	children	<b>Long Term</b> add _____ cancel _____ <b>Disability</b> occupation: _____
	cancel	employee	spouse	children	
	change to: _____				
<b>Term Life</b>	add	employee	spouse	children	Complete if the coverage you are adding or changing is based on your salary. Salary \$ _____ year month hour biweekly weekly
	cancel	employee	spouse	children	
	change to: _____				
<b>Supplemental Term Life</b>	add	employee	spouse	children	*If "change to" is elected, provide the date: _____
	cancel	employee	spouse	children	
	change to: amount \$ _____				

\* Proof of good health and Nippon Life Insurance Company of America (Nippon Life Benefits) approval may be required for increased benefit amounts.

**Reason for Adding a Coverage or Dependent**

marriage	loss of other group coverage*	open enrollment**	Date of event _____
birth/adoption	court order (attach a copy)	other _____	

\*For loss of other group coverage, you must complete the following:

Name of prior medical carrier _____	Date coverage ended _____
Name of prior dental carrier _____	Date coverage ended _____
Name of prior life carrier _____	Date coverage ended _____

Reason for lost group coverage: \_\_\_\_\_

\*\*If applicable to your group policy. Refer to your booklet certificate.

**You must complete Pages 1 – 3.**

**Reason for Canceling a Coverage or Dependent**

Date of request/ineligibility \_\_\_\_\_

 divorce spouse's group coverage Medicare  
 age limit individual insurance other \_\_\_\_\_
**Beneficiary Designation** (Complete if adding life coverage or changing beneficiary)

Full name \_\_\_\_\_

Relationship \_\_\_\_\_

If two or more beneficiaries are named, proceeds will be paid in equal shares to the surviving beneficiaries unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

**Complete for Adding or Canceling a Dependent** (Include last name if different from the employee)

Spouse's name \_\_\_\_\_

Birth date \_\_\_\_\_

Social security number \_\_\_\_\_

male female

**NOTE: The Full-time student information below is not applicable to dependent children less than 26 years of age who are applying for Medical coverage.**

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number	Full-time student		Foster child		Handicapped child		Male	Female
			Yes	No	Yes	No	Yes	No		
1.			Yes	No	Yes	No	Yes	No		
2.			Yes	No	Yes	No	Yes	No		
3.			Yes	No	Yes	No	Yes	No		
4.			Yes	No	Yes	No	Yes	No		
5.			Yes	No	Yes	No	Yes	No		

If you need additional space please attach a separate piece of paper.

Dependents must meet eligibility requirements. Contact your employer for the required forms. As allowed by state law, full-time student, foster child, and handicapped child eligibility may be subject to verification and approval by Nippon Life Benefits.

**Employee Signature** (Read and sign below.)**I understand and agree with the following statements:**

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted. (except for Florida)
- **If I cancel medical coverage for myself and my dependents, and then request coverage at a later date, I and my dependents will be considered a late enrollee. As a late enrollee, I and my dependents may not enroll until the next annual open enrollment period. However, I will not be considered a late enrollee for employee and dependent coverage (and will not have to wait until the next annual open enrollment period) if: (a) enrollment is requested under one of the special enrollment rights; (b) request is made within the time period specified for that special enrollment right; and (c) any required information or proof is furnished. Refer to your booklet for more details.**
- If I cancel dental coverage, I and my dependents may enroll at a later date; however, enrolling late will affect the level of dental benefits.
- If I cancel any type of life and disability coverage, I may apply at a later date; however, I must provide proof of good health at my own expense and coverage will only become effective subject to approval from Nippon Life Benefits.
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law. (except for Virginia)

**Employee Signature** (continued)

Any person who knowingly and with intent to defraud any insurance company or other person, submits any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia: Warning:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**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.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New York: (not applicable to Life Only coverage)** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**Virginia:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Your signature \_\_\_\_\_ Date signed \_\_\_\_\_

**Note – Make two copies: one for employer and one for employee**