Complete this form online at:
unum.com/esign/CS-1246

COVERAGE CHANGE REQUEST

Use this form to make changes to your Unum coverage outside of your company's enrollment period. Changes you can make include updating your name, changing your tobacco status and decreasing or canceling coverage.

How do I fill out this form?

For Employers:

- Complete the form online at: unum.com/esign/CS-1246 (or provide this link to the employee requesting the change).
- OR select the changes you need to make and provide the details we ask for, then return the form:
  - Fax to: **207-771-4019** | Mail to: **2211 Congress Street, Portland, ME 04122**
- If you're stuck or need help, please call Ask Unum at 1-800-275-8686.

For Employees:

- Complete the form online at unum.com/esign/CS-1246
- If you're stuck or need help, please ask your employer for guidance.

You can't use this form to:

- Enroll in new coverage or add a dependent. (You need to complete an enrollment form to do that.)
- Change a beneficiary. (Please notify your plan administrator to do that.)

I want to: (select)

☐ Change my name ☐ Change my tobacco status ☐ Decrease my coverage amount ☐ Cancel my coverage

Employee information: Please complete this section to begin.

Employer name

Policy number

Employee name (Last, First)

Social Security Number

Change name:

Previous name (Last, First)

New name (Last, First)

Change tobacco status: Your tobacco use can change the premiums we charge for coverage.

Have you used cigarettes, cigars, snuff, chew, a pipe or any nicotine delivery system in the past 12 months?

☐ Yes ☐ No

Decrease coverage:

This decrease is for: (select) ☐ myself ☐ my spouse ☐ my child(ren)

NOTE:
If you decrease coverage for yourself, your spouse or your child(ren), you may need to complete an Evidence of Insurability (Statement of Health) if you decide to re-apply for coverage in the future.

Date you would like decrease to occur:

MM / DD / YYYY

Decrease my Life coverage amount to: $

Decrease my AD&D coverage amount to: $

Decrease my Critical Illness coverage amount to: $

Decrease my spouse's Life coverage amount to: $

Decrease my spouse's AD&D coverage amount to: $

Decrease my child(ren)'s Life coverage amount to: $

Decrease my child(ren)'s AD&D coverage amount to: $

Cancel coverage:

This cancellation is for: (select) ☐ myself ☐ my spouse ☐ my child(ren)[1]

NOTE:
If you cancel coverage for yourself, and you carry coverage for your spouse/child(ren) on the same policy, their coverage will also be cancelled. If you decide to re-apply for coverage in the future, you may be required to complete an Evidence of Insurability (Statement of Health).

Is the cancellation due to a divorce, death or a child reaching the age limit on your policy? ☐ Yes ☐ No

If you answered yes to the question above, please enter the date of that event (we will use this date to cancel your coverage).

MM / DD / YYYY

Coverage you wish to cancel: (select)

☐ Life

☐ Accidental Death & Dismemberment

☐ Long Term Disability

☐ Short Term Disability

☐ Critical Illness[2]

☐ All

Sign this form: You must sign this form to complete the change process.

Signature X

Date

1 For Critical Illness benefits: Child coverage is included for no additional charge. It cannot be changed or canceled.
2 In North Carolina, "Critical Illness" benefits are referred to as "Specified Disease."