Lincoln Financial Group®

Lincoln Life & Annuity Company of New York
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Please Fax to (877) 573-6177
Total pages faxed _____

GROUP INSURANCE CHANGE REQUEST

Employer: _____

Policy Number (List all affected policy numbers): _____

Group ID: _____ Insured's Name: _____ Social Security Number: _____

NAME/ADDRESS CHANGE (First-MI-Last):
From:
To:

BENEFICIARY CHANGE	
Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:
NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet of paper.	

DEPENDENTS TO BE ADDED OR REMOVED

Check One Add	Check One Remove	Name (First-MI-Last)	Date of Birth (Mo. Day Yr.)	Relationship (Spouse or Child)	Date of Marriage (Mo. Day Yr.)	Late Entrant (Yes or No)

If adding dependent outside eligibility period, please explain reason:

For foster or adopted child, show date of placement and any adoption decree.
NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit it to Lincoln Life & Annuity Company of New York for review. If dependents are late entrants for Dental coverage, and were previously covered under another plan, please complete the back of this form.

CHANGES IN COVERAGE

Effective Date of Change: _____ **Current Salary:** $_____

☐ 1. Increase Employee coverage to $ _____

☐ 2. Add/increase spouse coverage to $ _____

☐ 3. Add Dependent Life Coverage $ _____

Enrollment form must be attached for items 1-3. Evidence of Insurability may be required.

Effective Date of Change: _____

☐ 1. Reduce Employee coverage to $ _____

☐ 2. Reduce spouse coverage to $ _____

Date: Insured's Signature: Witness' Signature:

REQUEST FOR REPLACEMENT CERTIFICATION
_____ I am requesting a duplicate group insurance certificate.

REQUEST FOR REPLACEMENT IDENTIFICATION CARDS
_____ I am requesting duplicate group insurance identification cards.

REQUEST FOR REPLACEMENT GROUP DENTAL INSURANCE

Information Regarding Employee:

1. Name of Employee Requesting Coverage:

2. Employer's Name and Address:

3. Employer's Policy Number:

Information Regarding Previous Plan:

1. Termination Date of Previous Plan:

2. Reason for Termination of Previous Plan:

PLEASE COMPLETE THE FOLLOWING:

Name of Employee or Dependent	***Covered Under Previous Plan***	***Requesting Coverage***	***Date of Birth***	***Social Security Number***

I request Group Dental Insurance to be effective _____ which is the day after Dental coverage provided through my previous group plan ends.

I previously refused or did not enroll for Dental coverage through my employer's group plan only because (I/my) dependents (was/were) covered for benefits through a previous group plan. We have now become ineligible for coverage under this plan. With respect to any part of the requested coverage which is non-contributory (paid entirely by my employer), I waive any rights I may have to coverage earlier than the above stated date.

Date: Employee Signature