

Term Life Insurance Change Form

Life Insurance Company of North America
Philadelphia, PA

For information and
customer service,
call 1-800-732-1603



CIGNA Group Insurance
Life • Accident • Disability

EMPLOYER _____	POLICY # _____		
REASON FOR REQUEST:	LIFE STATUS CHANGE	CANCEL COVERAGE	NAME CHANGE

EMPLOYEE SECTION

Mr. Mrs. Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____

I WISH TO MAKE THE FOLLOWING CHANGES TO MY LIFE INSURANCE COVERAGE

Life Status Change

If this change is being made due to a Life Status Change, please check one of the following, and provide date of change.

Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse/
Leave of Absence Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa)

Date of Life Status Change _____

Cancel coverage on the following individuals:

Employee Spouse Child(ren) Effective Date of Cancellation _____

Name Change: (Current Name / New Name)

Employee _____ / _____

Spouse _____ / _____

Employee Signature _____ Date _____

Be sure to make a copy of your form for your own records.