



SUPPLEMENTAL LIFE INSURANCE CHANGE REQUEST

To make a change to your current elections for supplemental life insurance and/or AD&D through The Hartford, complete all applicable fields, sign, date, and return to Benefits Staff via fax at 541-650-3031, encrypted email to BenefitsStaff@eugene-or.gov, or to 940 Willamette Street Suite 200, Eugene OR 97401.

PLAN INFORMATION

Name of Employer City of Eugene	Group/Plan Number GL-715287
------------------------------------	--------------------------------

EMPLOYEE INFORMATION

Employee Name (FIRST MI LAST)	Employee ID	Date of Birth
Address (STREET, CITY, STATE, ZIP)		Phone No.

NAME/CONTACT CHANGES

<input type="checkbox"/> Change Legal Name Previous Name _____ New Name _____ Reason for Change _____
<input type="checkbox"/> Change Contact Information To: Address (STREET, CITY, STATE, ZIP) _____ Phone No. _____

REDUCTIONS OR CANCELLATIONS OF EMPLOYEE PAID COVERAGE

The change applies to the following coverage:	Effective Date
<input type="checkbox"/> Supplemental Life (will also apply to AD&D coverage, if applicable) <input type="checkbox"/> AD&D only	
Coverage Reduction (increments of \$10,000 for Employee or Spouse/DP – Child Coverage is \$10,000, \$7,500, or \$5,000)	
<input type="checkbox"/> Reduce Employee Coverage from \$ _____ to \$ _____	
<input type="checkbox"/> Reduce Spouse/DP Coverage from \$ _____ to \$ _____	
<input type="checkbox"/> Reduce Child Coverage from \$ _____ to \$ _____	
Coverage Cancellation	
<input type="checkbox"/> Cancel Employee Coverage <input type="checkbox"/> Cancel Spouse/DP Coverage <input type="checkbox"/> Cancel Child Coverage	

Employee Signature	Date
--------------------	------

Benefit Staff Use:

Date Received _____ Eff. Date _____ Change Requested in PS _____