



BROKERS NATIONAL LIFE ASSURANCE COMPANY

Insurance Change Card, for:

- Dental Coverage
- Vision Coverage

- Add the following Dependents
- Cancel My Coverage
- Cancel the following Dependents Only

- Change Name/Address

GROUP # (IF APPLICABLE)	EMPLOYEE'S NAME	SS#
EMPLOYER NAME		
NAME (SPOUSE)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
REQUESTED EFFECTIVE DATE OF CHANGE	EMPLOYEE'S SIGNATURE	DATE

DV-Change(2001)

Complete Reverse Side of Card



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NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
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NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
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NAME (CHILD)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
REQUESTED EFFECTIVE DATE OF CHANGE	EMPLOYEE'S SIGNATURE	DATE

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Complete Reverse Side of Card

<input type="checkbox"/> New Name	<input type="checkbox"/> New Address
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Reason for Change:

- Open Enrollment – Date _____
- Adoption/Guardianship – Date _____ (*Attach Documentation*)
- Marriage – Date of Marriage _____
- Other Coverage Stopped – Date Coverage Stopped _____ (*Attach Previous Coverage Information*)
- Other _____

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New Enrollees must complete an Enrollment Application Form

<input type="checkbox"/> New Name	<input type="checkbox"/> New Address
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Reason for Change:

- Open Enrollment – Date _____
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