GROUP ADMINISTRATORS, LTD.
953 American Lane, Suite 100
Schaumburg, IL 60173 (847) 519-1880

CHANGE OF STATUS FORM

EMPLOYER NAME _____

EMPLOYEE NAME _____ SS# _____

DIVISION # _____ EFFECTIVE DATE OF CHANGE _____

TYPE OF CHANGE

✓	Change to be made	From	To
_____	Division Change	_____	_____
_____	Annual Salary	_____	_____
_____	Life Amount	_____	_____
_____	Optional Employee Life Coverage	_____	_____
_____	Optional Dependent Life Coverage	_____	_____
_____	Add Dependents (List Below)		
_____	Delete Dependents (List Below)		
_____	Marital Status	_____	_____
_____	Name	_____	_____
_____	Address Change		_____

DEPENDENT INFORMATION

List Dependents to be added or deleted:

Name	DOB	Relation	SS#

REASON FOR CHANGE

Divorce	Date
Legal Separation	Date
Marriage	Date
Birth (of Child)	Date
Spouse lost coverage with his/her employer	Date

BENEFICIARY

At the time of my death, please pay life insurance to:

	Name	Relationship	%
Primary			
Primary			
Primary			
Contingent			
Contingent			
Contingent			

SIGNATURE

_____ _____
Employee Date

_____ _____
Plan Administrator Date