Request for Change

ING
EMPLOYEE BENEFITS

ReliaStar Life Insurance Company
P.O. Box 20, Minneapolis, Minnesota 55440

Instructions:

Employee: Complete form and sign as required below.
Return this form to your employer.

Employer: Process the change(s), as necessary.
Place the original in the employee's permanent file.

Insured *(last name, first, middle initial)*		Date of Birth	Social Security #
Plan #	Account #	Policy/Certificate #	

Policy Changes

❒ Change name of ____ Insured _____Owner

Previous name	New name
Reason for change: *(If court order, attach copy)*	

❒ Change address to: *(Include zip code)*

_____

❒ Issue duplicate policy/certificate

Coverage Reduction

❒ Reduce employee coverage from $_____ to $_____ effective *(month, day, year)* _____

❒ Reduce spouse coverage from $_____ to $_____ effective *(month, day, year)* _____

❒ Reduce children's coverage from $_____ to $_____ effective *(month, day, year)* _____

Coverage Cancellations

❒ Cancel policy/certificate effective *(month, day, year)* _____

❒ Cancel spouse coverage effective *(month, day, year)* _____

❒ Cancel children's coverage effective *(month, day, year)* _____

Youngest child reached maximum age *(see policy) (month, day, year)* _____ *(Attach a copy of birth certificate).*

Signature of Employee *(required)*	Date Signed
Signature of Spouse *(if change affecting spouse coverage)*	Date Signed
Signature of Employer/Plan Administrator	Date Signed

FOR EMPLOYER/PLAN ADMINISTRATOR USE

Date received	Date processed	Processed by