

Faxable Change Document



ASSURANT Employee Benefits

To _____ Fax 888.208.2323 Date _____
 From _____ Fax _____ Telephone _____
 RE: Policyholder name _____ Policy no. _____
 E-mail address _____ Group Sales Office _____ No. of pages _____

Check here if any of the above information has changed.

Message _____

Employee Termination of Employment and Salary Changes					
Cert no.	Employee name	Termination		Salary change	
		Reason	Last day worked	Effective date	New salary amt.
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____
_____	_____	_____	_____	_____	\$ _____ Per _____

This form is not intended to replace the Employee Application or to enroll a new employee.

Employee Name Change (Please print or type.)

Certificate number _____ Old name _____ New name _____

Request for Coverage Change

Certificate number _____ Effective date _____ Employee name _____

Dependent coverage: Add Delete

Spouse Date of marriage _____ Date of death or divorce _____

Child Date of birth _____ Other qualifying event and date _____

You may also report terminations or changes by calling 800.733.7879 or E-mailing cr4kc@assurant.com.

Please **mail premium checks separately** in the enclosed envelope with your remittance stub.

Please mail enrollment applications or other changes to:

P.O. Box 2939
 Clinton, IA 52733-2939

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.