MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

REQUEST FOR SERVICE Insured Employee

Mail to above address.

(Type or Print)

Employer's Name ______________________ Group Number: State | Group Number | Division ______

Employer's Address ______________________ (Street, City, State, Zip Code)

Telephone Number ______________________ (Area Code, Number) Correspondence to: ______________________

Please check boxes below for desired action and provide requested information, if any.

☐ Termination of Insured Employee

Name of Employee __________ Certificate # __________ Soc. Sec. # ___ – ___ – ___ Termination Date __________

Name of Employee __________ Certificate # __________ Soc. Sec. # ___ – ___ – ___ Termination Date __________

Signature of Company Representative ______________________ Date __________

☐ Addition of Dependent Coverage

I hereby apply for Dependents Group Insurance Coverage for which I am or may become eligible under the Group Insurance Contract issued to my Employer and authorize the deduction from my earnings (if contributory) of the amount required to cover my share of the premiums. Unless dependents are newly acquired (e.g. newborn or through marriage), and we are not notified within 31 days of their acquisitions, they are considered late entrants, and evidence of insurability is required. Coverage will be effective the first of the month following approval.

Names of *ALL* Eligible Dependents

Last	First	Relationship	Date Acquired*

Signature of Insured Employee Requesting Change __________ Soc. Sec. # ___ – ___ – ___ Date __________

*(1) For an Eligible Spouse – give date of marriage. (2) For Adopted Children – give date of legal adoption.
(3) For Step-Children acquired by marriage – give date of marriage. (4) For your other children – give their dates of birth.

☐ Termination of Dependent Coverage

I no longer wish coverage on my dependents and request single coverage effective
(effective first of the month following receipt of the request)

Signature of Insured EmployeeTerminating Dependent Coverage __________ Soc. Sec. # ___ – ___ – ___ Date __________

☐ Insured Employee Name Change

From ______________________

To ______________________

Signature of Insured Employee Requesting Name Change __________ Soc. Sec. # ___ – ___ – ___ Date __________

☐ Insured Employee Address Change

Name ______________________

Address ______________________ (Street, City, State, Zip Code)

Signature of Company Representative ______________________ Date __________

☐ Class Change

Name of Employee __________ Soc. Sec. # __________ Effective Date __________
From Class __________ To Class __________

Name of Employee __________ Soc. Sec. # ___ – ___ – ___ Effective Date __________
From Class __________ To Class __________

Signature of Company Representative ______________________ Date __________

☐ Salary Change

Name of Employee __________ Soc. Sec. # ___ – ___ – ___ Effective Date __________
Previous Salary __________ New Salary __________

Name of Employee __________ Soc. Sec. # ___ – ___ – ___ Effective Date __________
Previous Salary __________ New Salary __________

Signature of Company Representative ______________________ Date __________

☐ Other ______________________ Date __________