MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

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

CHANGE FORM - VGL

Employee's Name _____ **Certificate Number** _____

Employer's Name _____ **Group Number** _____

Social Security Number _____ **Date of Birth** _____

Current Address _____
Street/PO Box City State Zip Code

Phone Number _____
Home Work

☐ **Cancel VGL policy as of*** _____
Month Year

I am authorizing MLHIC to cancel my policy. I have notified my payroll department to stop deductions.

Signature of Employee_____Date _____

☐ **Address Change**

Insured Name _____

New Address _____
Street/PO Box City State Zip Code

Signature of Insured _____ Date _____

☐ **Drop Family Coverage - Switch to single coverage****

Signature of Employee_____Date_____

☐ **Marriage Date** _____

Name Change from_____ **to** _____

Complete VGL Application to make any benefit changes.

Signature of Insured_____Date_____

☐ **Divorce Date** _____

Name Change from _____ **to** _____

☐ I no longer wish coverage on my spouse and dependents. Request single coverage only.

Spouse Name _____Date of Birth _____

☐ I no longer wish coverage on my spouse but continue coverage on my children. Premiums will remain the same.

Spouse Name _____Date of Birth _____

Signature of Insured _____Date _____

Send application to convert to spouse for coverage continuation: ***

Address: _____

_____

_____

Mail completed form to:
Medico Life and Health Insuance Company
PO Box 10386
Des Moines, IA 50306-0386

Conversion option is available for 31 days after termination.
**Cancellation date cannot be retroactive. Change must be made for future date. (Example: Cancellation requested 1/20/10. Policy will be cancelled 2/1/10).*
***Children ineligible*
**** Previous spouse can only continue coverage by converting.*