Nippon Life Benefits®

Nippon Life Insurance Company
of America
PO Box 25951
Shawnee Mission, KS 66225-5951

Employee Change Form - CA

Company name	Group/unit number

Employee Information (Change of name and address)

Your name (Last) (First) Social security number

New name (Last) (First)

New address* (Street) (City) (State) (ZIP)

*New address information is only needed if you have medical, dental or vision.

Complete for Adding, Canceling or Changing* a Coverage

Medical
- ☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ change to: _____

Dental
- ☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ change to: _____

In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no

Vision
- ☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ change to: _____

Term Life
- ☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
- ☐ change to: _____

*If "change to" is elected provide the date. _____

Supplemental Term Life ☐ add ☐ cancel
change to: amount _____

Short Term Disability ☐ add ☐ cancel
occupation: _____

Long Term Disability ☐ add ☐ cancel
occupation: _____

Complete if the coverage you are adding or changing is based on your salary:
Salary $ _____
☐ yr ☐ bi-wkly ☐ mo ☐ wkly ☐ hr

* Proof of good health and Nippon Life Insurance Company of America (Nippon Life Benefits) approval may be required for increased benefit amounts.

Reason for Adding a Coverage or Dependent

☐ marriage ☐ domestic partnership ☐ open enrollment (if applicable to your group policy, refer to your booklet certificate)
☐ birth/adoption ☐ court order (attach a copy) ☐ loss of other group coverage*
☐ other _____

Date of event

*For loss of other group coverage, you must complete the following:

Name of prior medical carrier _____ Date coverage ended

Name of prior dental carrier _____ Date coverage ended

Name of prior life carrier _____ Date coverage ended

Reason for lost group coverage _____

You must complete Page 1 - 3 of this form.

Reason for Canceling a Coverage or Dependent

☐ divorce ☐ dissolution of domestic partnership ☐ spouse's or domestic partner's group coverage

☐ age limit ☐ individual insurance ☐ Medicare

☐ other _____

Date of request/ineligibility

Beneficiary Designation *(Complete if adding life coverage or changing beneficiary)*

Full name | Relationship

If two or more beneficiaries are named, proceeds will be paid in equal shares to the surviving beneficiaries unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

Complete for Adding or Canceling a Dependent (include last name if different from the employee)

Spouse or domestic partner's name | Birth date | ☐ male ☐ female | Social security number

NOTE: The Full-time student information below is not applicable to dependent children less than 26 years of age who are applying for Medical, Dental or Vision coverage.

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number	Full-time student	Foster child	Handicapped child	Male	Female
1.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
2.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
3.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
4.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
5.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐

If you need additional space please attach a separate piece of paper.

Are any of the dependents listed above full-time employees who are eligible for an employer sponsored health plan? ☐ **Yes** ☐ **No**

If yes, please identify: _____

Dependents must meet eligibility requirements. Contact your employer for the required forms. As allowed by state law, eligibility for full-time students, foster children, handicapped children and a domestic partner's children may be subject to verification and approval by Nippon Life Benefits.

Employee Signature (Read and sign below)

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- **If I cancel medical coverage for myself and/or my dependents, and then request coverage at a later date, I and/or my dependents will be considered a late enrollee. As a late enrollee, I and/or my dependents may be subject to a late enrollee deferral or may not enroll until the next annual open enrollment period and/or may be subject to the preexisting condition exclusion (ask your employer which late enrollee option is included in the group policy.) However, I will not be considered a late enrollee for employee and/or dependent coverage (and will not have to wait until the next annual open enrollment period) if: (a) enrollment is requested under one of the special enrollment rights; (b) request is made within the time period specified for that special enrollment right; and (c) any required information or proof is furnished. Refer to your booklet for more details.**
- If I cancel dental coverage, I and/or my dependents may enroll at a later date; however, enrolling late will affect the level of dental benefits.
- If I cancel any type of life and/or disability coverage, I may apply at a later date; however, I must provide proof of good health at my own expense and coverage will only become effective subject to approval from Nippon Life Benefits.
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law.

Print

Employee Signature (continued)

I declare that the information I have completed on this change form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Nippon Life Benefits.

Your signature **X** _____ **Date signed** _____

Note – Make two copies: one for employer and one for employee