

Faxable Change Document



To _____ Fax 1-(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 _____
_____	_____	_____	_____	_____	\$ _____ Per _____

This form is not intended to replace the Fortis 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 can report terminations or changes by calling 1-(800)-733-7879.

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