GROUP BENEFIT SOLUTIONS

CLEAR FORM

NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577
Des Moines, IA 50306-3577
1.800.231.1193

Voluntary Term Life Insurance Personal Accident Insurance Change Form

Cornell University - Active Employees Policy Numbers FLY980026 and YOK008416

- This form can only be used for employee-paid coverages.
- **Important:** Please enter all dates in mm/dd/yyyy format.
- **This form cannot be used for address changes. Submit address changes to Cornell University.**

Plan information including coverage options, qualified life events and more can be found on the NYL GBS Benefits Guide website. To access visit: hr.cornell.edu, open Workday and from your Home Screen or from the drop-down menu (on the upper left side of the screen), click on the "Benefits and Pay" icon, then open the "Benefits Provider Link" menu and click on "Life Insurance and Personal Accident (PAI) Active."

To review current coverage information or to review/update beneficiary designations, once on NYL GBS Benefits Guide, Click on "My Account".

Please print (preferably in black ink).

Employee Section

Name: *(First)* _____ *(Last)* _____

Social Security Number: _____ Birthdate: _____ Work Phone: _____

Home Phone: _____ Sex: ☐ M ☐ F

Above Section Must Be Fully Completed for All Requests Below

☐ **Name Change:** Please include a valid government-issued document (for example: marriage certificate, divorce decree/other court or official document). **Name changes must also be submitted directly to Cornell University.**

☐ Employee ***Current*** Name: _____ ***New*** Name: _____

☐ Spouse/Domestic Partner ***Current*** Name: _____ ***New*** Name: _____

Beneficiary Designations: To review your current beneficiary designations visit hr.cornell.edu, open Workday and from your Home Screen or from the drop-down menu, click on the "Benefits and Pay" icon, then open the "Benefits Provider Link" menu and click on "Life Insurance and Personal Accident (PAI) Active". Click "My Account" to review/update your current beneficiary designations.

Voluntary Term Life Insurance Coverage

CHECK THE APPROPRIATE BOXES:

☐ **Change coverage on the following individuals as indicated below:**

☐ Employee: I would like my insurance amount to match the following *(check one)*:

☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x ☐ 7x ☐ 8x ☐ 9x ☐ 10x Annual Salary.

☐ Spouse/Domestic Partner ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____

☐ Child(ren) ***Current*** Voluntary Coverage: _____ ***New*** Voluntary Coverage: _____

☐ **This change is due to a Life Status Change**

The Life Status Change is _____ Life Status Change Date: _____

Within 60 days after a Life Status Change, if you are currently insured, you may increase up to the Guaranteed Amount.

☐ **Cancel coverage on the following individuals:** ☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

Child(ren)'s coverage is a rider to the employee or spouse/domestic partner certificate. Child coverage will be cancelled if the employee or spouse/domestic partner certificate to which it is a rider is cancelled. If dependent coverage is being canceled due to loss of eligibility, conversion may be available. If interested, please contact the above number.

Is this your last dependent child? ☐ Yes ☐ No

My dependent child is no longer eligible for coverage as of the following date (mm/dd/yyyy): _____

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Personal Accident Insurance Coverage

☐ **Change coverage on the following individuals as indicated below:**

☐ Employee: Employee Benefit Amount $ _____

(in $10,000 increments up to $500,000. If you elect a benefit amount over $250,000, the amount cannot exceed 10 times your based annual salary.)

☐ Spouse/Domestic Partner: ☐ 100% of my benefit ☐ 50% of my benefit

☐ Dependent Child(ren): ☐ 10% of my benefit

☐ **Cancel coverage on the following individuals as indicated below:**

☐ Employee ☐ Spouse/Domestic Partner ☐ Child(ren)

Children's coverage is a rider to the employee or spouse/domestic partner certificate. Child coverage will be cancelled if the employee or spouse/domestic partner certificate to which it is a rider is cancelled. If dependent coverage is being cancelled due to loss of eligibility, conversion may be available. If interested, contact the number above.

Is this your last dependent child? ☐ Yes ☐ No My dependent child is no longer eligible for coverage as of the following date (mm/dd/yyyy): _____

Acceptance/Declination

I authorize the above changes to my Voluntary Term Life and Personal Accident Insurance. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to make the appropriate payroll deductions for changes noted above.

Signature:	Date (mm/dd/yyyy):
X	

Be sure to make a copy for your own records

Return the completed form:

By mail: Use the return envelope provided or mail to:
NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577
Des Moines, IA 50306-3577

By email: NYLGBSVolBenefits@mccamish.com

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