SERVICE REQUEST FORM

Certificate Number	Insured	Certificate holder (if other than insured)
Address		Phone Number

1. Change of Beneficiary (Note: The witness must be someone other than the beneficiary.)

Please change the beneficiary under the above certificate as follows:

Primary Beneficiary	Relationship to Insured
Address	
Contingent Beneficiary	Relationship to Insured
Address	

2. Change of Name (Please attach official documentation of the name change.)

Former Name	New Name
Reason for Change	

3. Change of Address

Former Address	
New Address	Phone Number

4. Cancellation/Change of Coverage
Requested Effective Date of Cancellation:

I have reviewed the benefits of the plan and have decided to cancel my coverage. I understand that by waiving my rights to continue my coverage, I may be required to show evidence of insurability to re-qualify for coverage.

Critical Illness	Hospital Indemnity	Accident
☐ Employee ☐ Spouse*	☐ Employee ☐ Spouse* * ☐ Child*	☐ Employee ☐ Spouse* ☐ Child*

*If you have spouse or dependent coverage on the plan(s) you wish to cancel, please indicate whether you wish to cancel the entire plan **or** only coverage for your spouse and/or dependent child. If you would like to cancel your spouse and/or dependent coverage, please provide each name and date of birth below:

Name(s) and Date(s) of Birth:

Please sign and date here for above requests:

Date	Signature of Owner
Witness	
Signature of Signee (if applicable)	Signature of Irrevocable Beneficiary (if any)

Return to: **Mail:** CAIC • P.O. Box 427 • Columbia, SC 29202 • **Fax:** 866. 849.2974 • **Email:** csc@caicworksite.com
Questions? **Toll-Free:** 1.888.687.1883