MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

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

Request for Service Employer/Group

Employer's Name _____ Group Name _____
(Type or Print) State Group Division

Employer's Address _____
Street City State Zip Code

Telephone Number _____ Contact Person: _____
Area Code Number

Please check boxes below for desired action. Phone Number: _____

☐ **Change/Correct**

☐ Employer Name
☐ Employer Address

Name _____

Number Street Suite _____

City State Zip Code _____

Change the waiting period for new full-time Employees from _____ month(s) to _____month(s) of continuous active full time service. Is this waiting period to apply to present full-time employees who have not become eligible prior to the effective date of this change? ☐ Yes ☐ No

Effective Date_____

☐ Change Reduction and Termination Provision:

LIFE	AD&D	STD
Reduces____% at age_____	Reduces____% at age _____	
Reduces____% at age_____	Reduces____% at age _____	
Term at age _____	Term at age _____	Term at age _____

Effective Date_____

☐ Change the plan to a: ☐ Contributory ☐ Non-Contributory basis

If Contributory _____% of employee contribution: Life_____ Dependent Life_____ Disability_____ Effective Date_____

☐ Change ☐ Benefits ☐ Classification

	CLASSIFICATION i.e. Managers, Supervisors	**LIFE**	**AD&D**	**STD***	**DEPENDENT LIFE**
1					
2					
3					
4					

**Benefits may not exceed 66-2/3% of basic weekly earnings*

Effective Date_____

☐ **Other Changes**_____

_____ Effective Date_____

It is requested that these changes be effective at 12:01 A.M. on the effective date(s) shown above. I understand and agree that any increase in benefits with respect to any insured Employee shall become effective only if such Employee is in active full-time work on the effective date of the increase in benefits; otherwise, such increase in benefits shall become effective on the date of such Employee's return to active full-time work. If a dependent is confined in a hospital on the date an Employee would otherwise become insured with respect to such dependent, the insurance with respect to such dependent shall be deferred until the final discharge from the hospital.

Date _____ Signature _____
(Authorized Company Representative)

Witness_____ Title _____

Do not write below this line

Date _____ _____
(Medico Life and Health Insurance Company Authorized Representative)