SERVICE / CHANGE FORM

Please complete this form and fax to AssuredPartners at 515-237-0190, Attention: Enrollment Admin or via email to lmcins.enroll@assuredpartners.com.

The following event(s) have occurred which may affect my benefits. Please send the necessary forms to my attention:

DATE OF EVENT

- ☐ MARRIAGE _____
- ☐ BIRTH OR ADOPTION OF CHILD _____
- ☐ DIVORCE _____
- ☐ BENEFICIARY CHANGE _____
- ☐ TERMINATION OF EMPLOYMENT _____
  - ☐ Voluntary ☐ Involuntary
  - Date of last paycheck _____
- ☐ DEATH _____
- ☐ DEPENDENT NO LONGER ELIGIBLE _____
- ☐ MEDICAL OR DENTAL CLAIM INQUIRY
- ☐ OTHER. PLEASE PROVIDE DETAILS:

_____

_____

_____ _____

Employee Name | Social Security Number

_____ _____

Person completing form, if different | Date

_____ _____

Name of School/Parish | Phone Number