Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

5011 GATE PARKWAY, BLDG. 200
JACKSONVILLE, FLORIDA 32256
1-800-333-3256

GROUP CERTIFICATE CHANGE FORM

(SEE REVERSE SIDE FOR INSTRUCTIONS)
Please Type or Print In Black Ink

Group Name:	FCL Group Number:	BCBSF Group Number:
Employee Name:	Employee Social Security Number:	

A CHANGE OF NAME (To be completed by the Insured Employee)

The name of the above insured employee should be changed to the following:

Last Name:	First Name:	Middle Initial

This change is due to: ☐ Marriage ☐ Court Order *(Attach copy of the court order.)*

B CHANGE OF BENEFICIARY (To be completed by the Insured Employee)

Under and subject to the terms of the above group policy number, I hereby annul and revoke any former beneficiary(s) named by me, and I now designate the following person(s) as beneficiary(s). I understand that proceeds will be paid in equal shares or to the survivor(s) when such payment is applicable, if % of share is not indicated. *(If you have forfeited your right to change the beneficiary on your certificate, the irrevocable beneficiary and, if applicable, the absolute assignee must sign in Section D.)*

	Last Name	First Name	MI	Relationship to Insured	% of Share
Primary					
Primary					
Contingent					
Contingent					

C CHANGE IN COVERAGE (To be completed by the Employer)

The following changes are to be effective with the next premium due date (MM/DD/YY):

Is the employee terminating his or her employment with you? ☐ Yes ☐ No

If yes, provide the employee's termination date (MM/DD/YY):

Change in Class:	From:	To:	Change in Annual Salary:	From: $	To: $

Type of Coverage	Termination of Coverage	Change in Coverage	From Amount of Coverage	To Amount of Coverage
Employee Term Life	☐	☐	$	$
Employee AD&D	☐	☐	$	$
Supplemental Term Life	☐	☐	$	$
Supplemental AD&D	☐	☐	$	$
Dependent Life	☐	☐	$	$
Short Term Disability	☐	☐	$	$
Long Term Disability	☐	☐	$	$
Voluntary Term Life - Employee	☐	☐	$	$
Voluntary Term Life - Spouse	☐	☐	$	$
Voluntary Term Life - Child(ren)	☐	☐	$	$
Voluntary Long Term Disability	☐	☐	$	$
Voluntary Short Term Disability	☐	☐	$	$
Other:	☐	☐	$	$
Other:	☐	☐	$	$
Other:	☐	☐	$	$

Dependent Life coverage must be requested within 31 days from the date the dependent becomes eligible for coverage.
Please indicate the reason dependent life coverage is being added:

☐ Marriage	(MM/DD/YY)	☐ Adoption	(MM/DD/YY)
☐ Birth	(MM/DD/YY)	☐ Other (Provide details below)	(MM/DD/YY)

Details for Addition of Dependent Life Coverage:

D SIGNATURES (To be signed by the Employee and, when applicable, the Irrevocable Beneficiary, Absolute Assignee, and Employer)

This form serves as a request and authorization to change the certificate as indicated above.

Employee's signature:	Date:
Irrevocable Beneficiary signature:	Date:
Absolute Assignee signature:	Date:
Employer's signature:	Date:

Employer Name and Address (Must be completed for acknowledgment to be returned)	Home Office Endorsement
	Date:
	Signed:

INSTRUCTIONS

NOTE: ALL CHANGES MADE ON THIS FORM APPLY TO FLORIDA COMBINED LIFE INSURANCE COMPANY, INC. LIFE AND DISABILITY COVERAGES **ONLY.**

To make a change of name, change of beneficiary, or change in coverage, complete the appropriate section (A, B, and/or C), and the employer's name and address section at the bottom of the form. A recorded copy of the requested change(s) will not be returned if the employer's name and address have not been supplied. The employee, irrevocable beneficiary, absolute assignee, and employer, as applicable, must sign the appropriate signature line in Section D.

Please complete all required information. Incomplete information may result in delays in processing the requested change(s). Make a copy for yourself and for your employer, and send the original completed copy to Florida Combined Life Insurance Company, Inc. These changes can only become effective when recorded at Florida Combined Life Insurance Company, Inc.

Any questions should be directed to the Customer Service Department at 1-800-333-3256.

Change of Name (Section A)	Complete this section if your name has been changed by marriage or court order. If the name change is due to a court order, please attach a copy of the order. Sign the appropriate signature line in Section D.
Change of Beneficiary (Section B)	Complete this section to change the beneficiary(s). If you have forfeited your right to change the beneficiary on your certificate, the irrevocable beneficiary's and, if applicable, absolute assignee's signature is required in Section D. The full legal name(s) and relationship(s) of the beneficiary(s) are required. Remember to fill in the % of share if proceeds are to be divided between two or more beneficiaries. The employee, irrevocable beneficiary, and absolute assignee if applicable, must sign the appropriate signature line in Section D.
Change in Coverage (Section C)	Complete this section for: (1) changes to an insured employee's existing coverage(s), including the addition of coverage(s); and (2) terminating coverage(s). The employee, absolute assignee if applicable, and employer must sign the appropriate signature line in Section D. Changes in coverage will be limited to the plans, and amounts, selected by the employer on the master application and any subsequent amendment.
Signatures (Section D)	Florida Combined Life Insurance Company, Inc. will not process any change without the employee's signature and, when applicable, the irrevocable beneficiary's, absolute assignee's, and employer's signature.