ASSURITY LIFE INSURANCE COMPAY

GROUP INSURANCE CHANGE REQUEST

GROUP __02339__ CERT. _____

POLICY HOLDER___LINCOLN EDUCATION ASSOCIATION_____

LEA MEMBER'S NAME _____

☐ Name change from _____ to _____

☐ Beneficiary changed to _____
(Name) (Relationship)

☐ Secondary Beneficiaries (if applicable):
Name(s) Relationship
_____
_____
_____
_____

Employee's Signature _____ Date _____

Return to the LEA Office
Inter-School Mail (no box #) or through
U.S. Mail at: 4920 Normal Blvd, Lincoln NE 68506

G-593 Rev. 3/05