



Self-Administered Employee Change

GROUP ACCOUNT NAME:

GROUP ACCOUNT NUMBER:

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
100 Bright Meadow Boulevard
PO Box 1955
Enfield, CT 06083-1955

A. Additions

NAME	SEX	DATE OF BIRTH	DATE HIRED MO/DY/YR	EFF.. DATE OF COV.	* CODE	DENTAL OR MM CLASS CODE **	CLASS NO.	BASIC ANNUAL EARNINGS		LIFE INS. AMOUNT	SUPPL. LIFE INS. AMOUNT	W. I. AMOUNT	LTD MONTHLY COV. PAYROLL (NOT TO EXCEED MAX.)
								OLD	NEW				
Total Additions =		NO. OF EMPLOYEES	SINGLE	FAMILY	DEP			LIFE INS. AMT.	SUPPL. LIFE AMT.	W. I. AMT.	LTD MONTHLY COV. PAYROLL		

B. Increases

NAME	SEX	DATE OF BIRTH	DATE OF CHANGE	DENTAL OR MM CLASS CODE **	NEW CLASS NO.	BASIC ANNUAL EARNINGS		LIFE INS. DIFFERENCE	SUPPL. LIFE INS. DIFF.	W. I. AMOUNT DIFFERENCE	LTD MONTHLY COV. PAYROLL DIFFERENCE
						OLD	NEW				

Total Increases

***TOTAL ADDITIONS/INCREASES	LIFE INSURANCE DIFFERENCE		SUPPL. LIFE DIFFERENCE		WEEKLY INDEMNITY DIFFERENCE		LTD MONTHLY COV. PAYROLL DIFFERENCE	
	NO. OF EMPLOYEES	SINGLE	FAMILY	DEP.	LIFE INS. AMT.	SUPPL. INS. AMT.	W. I. INS. AMT.	LTD MONTHLY COV. PAYROLL

*EMPLOYEE CODES

- F - Full Time
- PTF - Part Time to Full Time
- RLO - Re-entry from Layoff
- CHC - Change to eligible Class
- RLA - Re-entry from Leave of Absence
- RS - Re-Entry from Strike
- O - Other (Please Explain)

**COVERAGE CODES

- DENTAL
- S - Employee only
 - F - Employee & Family
 - D - Employee & One Depend.

MAJOR MEDICAL

- S - Employee only
- F - Employee & Family
- D - Employee & One Depend.
- M - Medicare Election
- W - Either Employee or depend., other on Medicare
- N - No Health Coverage
- H - Employee covered by HMO
- C - Dependent covered by GE Group Life Employee elected Medicare (Please advise when depend. reaches 65)
- TS - Single MM continuance
- TF - Family MM continuance
- DS - Health continuance for divorced/widowed spouse
- DF - Health continuance for divorced/widowed spouse and family

***CODE

Transfer these changes to COLUMN TWO (2) on your Self-Administered Statement.

BE SURE TO COMPLETE ALL BLOCKS FOR EACH EMPLOYEE.

C. Terminations

NAME	SEX	DATE OF BIRTH	REASON FOR TERMINATION P.W. = PREMIUM WAIVER O = OTHER (PLEASE EXPLAIN)		DATE OF TERMINATION MO/DY/YR	DENTAL OR MM CLASS CODE **	LIFE INS. AMOUNT	SUPPL. LIFE INS. AMOUNT	WEEKLY IND. AMOUNT	LTD MONTHLY COV. PAYROLL (NOT TO EXCEED MAX.)
Total Terminations =		NO. OF EMPLOYEES	SINGLE	FAMILY	DEP	LIFE INS. AMT.	SUPPL. LIFE AMT.	W. I. AMT.	LTD MONTHLY COV. PAYROLL	

D. Decreases (as allowed in your contract)

NAME	SEX	DATE OF BIRTH	DATE OF CHANGE	DENTAL OR MM CLASS CODE **	NEW CLASS	BASIC ANNUAL EARNINGS		LIFE INS. DIFFERENCE	SUPPL. LIFE DIFF.	W. I. DIFF.	LTD MONTHLY COV. PAYROLL DIFF.
						OLD	NEW				
Total Decreases =		LIFE INSURANCE DIFFERENCE			SUPPL. LIFE DIFFERENCE		WEEKLY INDEMNITY DIFFERENCE		LTD MONTHLY COV. PAYROLL DIFFERENCE		
****Total Terminations = and Decreases		NO. OF EMPLOYEES	SINGLE	FAMILY	DEP.	LIFE INS. AMT.	SUPP. LIFE AMT.	WEEK IND. AMT.	LTD MONTHLY COV. PAYROLL		

NOTE: If Major Medical is part of your plan, and an insured is changing from S to F coverage show the old code as a decrease in Section "D", and the new code as an increase in Section "B", and also provide reason for change.

Additions and changes may be subject to evidence of insurability requirements; such as in the case of late applicants, supplemental insurance, and class changes in which additional amounts of insurance are requested.

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*****CODE**

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******CODE**

Transfer these changes to COLUMN THREE (3) on your Self-Administered Statement.