Certificate No. _____ -05

NBUSA Nazarene Benefits

Request For Change
Long-Term Disability Insurance

Name of Insured _____

Social Security No. _____

I hereby request that the benefit amount for my coverage be changed to _____ .

Please make this change effective _____ , or as soon thereafter as possible.

I understand that when I choose to increase my benefit level, a new preexisting conditions limitations period will apply on the increase.

_____ _____
Date Signature in ink

NOTICE OF PREEXISTING CONDITIONS LIMITATIONS: Coverage is issued with a preexisting conditions limitation. If you have received treatment for a medical condition within the 6 months immediately preceding the date your coverage is effective, then you must satisfy one of the following: (1) go 6 months free of treatment on or after your effective date; or (2) be insured for 12 months even with treatment. **This preexisting conditions limitation does not apply to any other cause of disability.**

Please return completed and signed form to NBUSA.

FOR NBUSA OFFICE USE ONLY

Received _____ Effective Date _____

NBUSA Nazarene Benefits

17001 Prairie Star Pkwy, Lenexa, KS 66220-7900
888.888.4656 | (FAX) 800.334.0634 | nbusa.org | benefits@nazarene.org