ADA Members Insurance Plans

www.insurance.ada.org

GREAT-WEST FINANCIAL

P.O. Box 340
Denver, CO 80201
Phone 800-568-2001
Fax 303-737-4843
ada@greatwest.com

REQUEST FOR CHANGE OF BENEFIT PLAN
ADA OFFICE OVERHEAD EXPENSE PLAN

ADA MEMBER NAME:_____

ADA MEMBER NUMBER:_____ DATE OF BIRTH:_____

DAYTIME PHONE:_____ FAX:_____

EMAIL:_____

Please complete this form and return it to Great-West Financial by fax, email or mail.

Your Benefit Plan change will become effective either (a) on the date this completed form is received by Great-West Financial, or (b) on the premium due date if this request is received during the Days of Grace (within 30 days of the Billing Due date), subject to payment of any premium due, and subject to underwriting approval (if required).

Any unused premium that has been paid for the 24 Times Benefit Plan that is in excess of the premium due for the 12 Times Benefit Plan will be refunded.

DESIGNATION OF BENEFIT PLAN

I hereby request to change my Benefit Plan to:

☐ 24 Times monthly insured amount (application required*)
☐ 12 Times monthly insured amount

I understand that the Overall Maximum benefit payable under the 12 Times Monthly Benefit Plan may be less than that payable under the 24 Times Monthly Benefit Plan. I also understand that only the benefit payment period is changing, and that my Monthly Insured Amount will not change.

Signature of Member:_____ Date:_____

* If, at any time, you request the 24 Times Benefit Plan, that request must be made by completing an application for insurance and will be subject to standard medical and financial underwriting. Approval of that request and payment of any benefits will be subject to all terms and provisions of the ADA Office Overhead Expense Plan Group Policy #l106GDH-OEP.