Standard Insurance Company

900 SW Fifth Avenue Portland OR 97204-1282

Request for Group Insurance Amendment

EMPLOYER:	GROUP NUMBER:
City of Jackson MO	**168471**

As an authorized representative of the Employer,

1. I request that Standard Insurance Company ("The Standard") amend the above Employer's coverage under the Group Policy to make the following change(s):

Effective 1/1/2023, change UCR to 80th

2. I request that the amendment become effective on **1/1/23**.
   I understand that the amendment will not become effective unless approved and issued by The Standard.
3. I request that the amendment be approved by The Standard subject to The Standard's usual underwriting requirements, including, if applicable, Evidence Of Insurability or a Pre-existing Condition provision.
4. I understand that the amendment, if approved by The Standard, will be issued in the policy language customarily used by The Standard.
5. I understand that any increase in Insurance for a Member who is not Actively At Work all day on the Member's last regular work day before the scheduled effective date of the amendment will be deferred until the first day after the Member completes one full day of Active Work.
6. I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Signed By:_____ **Title:**_____ **Date:**_____
Authorized Representative

Employee Benefits Consultant: Blake Huddleston **Employee Benefits Sales & Service Office:** St. Louis

Service Representative: Katie Miller **Date Received At Employee Benefits Sales & Service Office:**_____

EMPLOYEE BENEFITS CONSULTANT: Please be sure Supplemental Information is completed.

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Supplemental Information

To Be Completed by Employee Benefits Consultant. Please be sure the Employer clearly understands the change requested and any change in premium rates.

UNDERWRITING

Are there any changes to rates, lives, and/or volume created by this requested amendment? ☐ **Yes** ☑ **No**

If **yes,** complete the following information and attach census showing age, sex, and insurance amounts for persons to be added or dropped.

Specify coverage/suffix:				
*Quoted Rates				
*Approximate Volume Increase (Decrease):				
Lives Increase (Decrease):				

Proposal prepared by: ☐ Portland ☐ Employee Benefits Sales & Service Office ☐ South Portland ☐ None Prepared

Client ID No. _____

Rating Request No. _____

Is any Evidence Of Insurability required on the effective date? ☐ **Yes** ☐ **No** If **yes,** please attach forms.

*If these are separated by billing suffix, please specify suffix.

IMPORTANT NOTICES/REVISED CERTIFICATES

When we issue an Amendment, we will also issue **Notices of Plan Change.** All classifications will be shown in a single Notice. If it is necessary to split out classifications in separate Notices, or if the Employer needs new **Certificates,** please indicate as such in the COMMENTS section below.

Please indicate your preferred document delivery option:

☐ Via Admin*EASE*
☑ Via E-Mail to Employee Benefits Sales & Service Office
☐ Via Diskette to Employee Benefits Sales & Service Office

MAILING INSTRUCTIONS

Do you want the completed **Amendment** mailed to: ☐ **Employee Benefits Sales & Service Office**

*If not Employee Benefits Sales & Service Office, provide **BOTH** the Employer's and Producer's street addresses (No PO Boxes).

☐ Employer		☐ Producer	
NAME **City of Jackson**		NAME	
ATTN: **J.J. Wiseman**		ATTN:	
STREET ADDRESS **101 Court St**		STREET ADDRESS	
CITY **Jackson**		CITY	
STATE **MO**	ZIP CODE **63755**	STATE	ZIP CODE

COMMENTS