Third Party Administrator for
STATE OF MISSOURI
VOLUNTARY LIFE INSURANCE COMMISSION

# CHANGE FORM

## Missouri Payroll Clerks FAX to: (816) 531-7503

**PRINT EMPLOYEE NAME:**_____

**SSN:**_____ **EMPLOYEE DAY/WORK PHONE:**_____

**DEPARTMENT NAME:** _____

☐ **CANCELLATION OF INSURANCE COVERAGE (*attach a signed memo requesting cancellation by employee*).**

☐ **INCORRECT SSN:**
Our records indicate: _____/_____/_____ is the *correct* SSN.

The payroll authorization form received showed: _____/_____/_____ as the SSN.

☐ **ADDRESS CHANGE:** _____

City_____State_____Zip_____

☐ **CHANGE IN PAYROLL STATUS**:
The employee's last paycheck is/was dated: _____

☐ Transferred dept./division (*NEW* dept./div: _____)

☐ Termination date:_____

☐ Retirement date:_____

☐ Disability
☐ Death
☐ Other/Notes: _____

☐ The employee is on leave without pay, effective date of: _____

☐ The employee has returned to work after leave without pay, effective date: _____

**Name of PAYROLL CLERK who completed this form**: _____

**Dept/Div:** _____

**Phone: (_____)_____Email:** _____**Date:** _____


**866-668-5421**

**MoVLIC, 1100 Main Street Ste 2890, KC, MO 64105 816-221-1564**