

**CHANGE NOTICE**

Complete all areas clearly. Incomplete forms will cause a delay in approval.

**EMPLOYER: PLEASE COMPLETE THIS SECTION**

EMPLOYER NAME \_\_\_\_\_ SECTION NO: \_\_\_\_\_  
ADDRESS: STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

**PLEASE PRINT TELL US ABOUT YOURSELF**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INITIAL \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ IDENTIFICATION NUMBER \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

**IF THERE IS A CHANGE IN YOUR NAME OR ADDRESS, FILL IN BELOW**

PREVIOUS LAST NAME \_\_\_\_\_ NEW LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INITIAL \_\_\_\_\_  
NEW STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

REASON FOR CHANGE:  MARRIAGE  DIVORCE  OTHER \_\_\_\_\_ EFFECTIVE DATE OF CHANGE / /

**PLEASE INDICATE COVERAGE(S) AFFECTED SALARY CHANGE**

MEDICAL  DENTAL  VISION  LIFE  DEP. LIFE  LTD ANNUAL SALARY \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

**IF THERE ARE CHANGES IN THE COVERAGE(S) OF YOUR DEPENDENT(S), FILL IN BELOW**

**ADD** **CANCEL** **REASON & DATE**  
 Spouse only  Spouse only  Marriage \_\_\_ / \_\_\_ / \_\_\_  Other: (Describe): \_\_\_\_\_  
 Child(ren) only  Child(ren) only  Divorce \_\_\_ / \_\_\_ / \_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_  
 Spouse & Child(ren)  Spouse & Child(ren)  Death of Spouse \_\_\_ / \_\_\_ / \_\_\_  
**REQUESTED EFFECTIVE DATE** \_\_\_ / \_\_\_ / \_\_\_  New Dependent \_\_\_ / \_\_\_ / \_\_\_ **PREVIOUS NAME OF SPOUSE** \_\_\_\_\_

LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	SEX	DATE OF BIRTH MONTH DAY YEAR	STUDENT?	SOCIAL SECURITY NUMBER
SPOUSE						YES NO	
CHILD						YES NO	
CHILD						YES NO	
CHILD						YES NO	

**IF THERE IS A CHANGE IN YOUR OTHER INSURANCE INFORMATION, FILL IN BELOW**

Is anyone named in this application eligible for Medicare coverage?  
 Yes  No Name of Person(s) \_\_\_\_\_  
Reason:  Over 65  Disabled Date \_\_\_\_\_  
Part A. (Hosp) Effective Date \_\_\_\_\_ Part B. (Med.) Effective Date \_\_\_\_\_ Medicare Card No. Self \_\_\_\_\_ Spouse \_\_\_\_\_  
Does anyone named in this application have other insurance coverage?  Yes  No Complete the following information in this section.  
Type of Coverage  Medical  Dental  Vision  Drug  
Individual's Employer \_\_\_\_\_ Employer's Phone Number \_\_\_\_\_  
Name under which policy is listed \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Policy I.D. Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Single Plan  Family Plan Effective Date \_\_\_\_\_

**IF YOU ARE TRANSFERRING COVERAGE, PLEASE COMPLETE**

Will the coverage you are applying for replace a health, dental or vision insurance policy currently in force or a policy that has been terminated within the past 30 days?  
 Yes  No  Employer policy  Individual policy Type of coverage:  Medical  Dental  Vision  Drug  
Policy Holder's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Single Plan  Family Plan Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  
Policy I.D. Number \_\_\_\_\_ Group Number \_\_\_\_\_

**IF THERE IS A CHANGE OF LIFE BENEFICIARY, COMPLETE THIS SECTION**

	LAST NAME(S)	FIRST	INITIAL	RELATIONSHIP	% TO EACH
Primary (List Names)					
Contingent (List Names)					

**SIGNATURE**

I HEREBY REQUEST THE ABOVE-NOTED CHANGE. I UNDERSTAND FUTURE RE-ENROLLMENT MAY BE SUBJECT TO EVIDENCE OF INSURABILITY ENTIRELY AT MY OWN EXPENSE WHERE REQUIRED BY THE INSURANCE COMPANY. CHANGES AND RE-ENROLLMENTS ARE SUBJECT TO ALL CONTRACT TERMS AND CONDITIONS.

**X** \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**FOR EMPLOYER OFFICE USE ONLY**

**FOR TRUST USE ONLY**

Authorized Employer Signature: \_\_\_\_\_ Effective date of above noted change: \_\_\_\_\_  
Print Name and Title: \_\_\_\_\_ Signed: \_\_\_\_\_  
Date: \_\_\_\_\_ WBA Insurance Trust Enrollment Administrator Date \_\_\_\_\_