Return to: WISCONSIN BANKERS ASSOCIATION
INSURANCE TRUST
P. O. BOX 7697
MADISON, WI 53707-7697

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

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE ☐ DEP. LIFE ☐ LTD

SALARY CHANGE

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 Name of Person(s) ☐ No

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 Complete the following information in this section. ☐ No

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug

Individual's Employer | Employer's Phone Number

Name under which policy is listed | Social Security No. | ☐ Single Plan ☐ Family Plan | Effective Date

Name of Insurance Company | City | State | Policy I.D. Number | Group Number

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. | ☐ Single Plan ☐ Family Plan | Effective Date | Termination Date

Name of Insurance Company | City | State | 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

Authorized Employer Signature: _____

Print Name and Title: _____

Date: _____

FOR TRUST USE ONLY

Effective date of above noted change: _____

Signed: _____

WBA Insurance Trust Enrollment Administrator Date