

# CLEAT Benefit Plan & Trust Change Form

EMPLOYER PLAN SERVICES, INC. • 2180 North Loop West, Suite 400 • Houston, Texas 77018 • (713) 932-8917 • 1-800-447-6588

1053

Employer Name

Group No.

Employee Name (Last Name, First, Middle Initial)

Social Security Number

Employee Address

City

State

Zip

- Change address
- Change my name from \_\_\_\_\_ to \_\_\_\_\_
- I wish to Add coverage on myself       Dental       Vision
- I wish to Terminate coverage on myself       Dental       Vision      Date of change \_\_\_\_\_
- I wish to Add coverage on my dependents       Dental       Vision
- I acquired dependents by:       Marriage       Adoption      on Date: \_\_\_\_\_
- Birth       Court Order
- Other:      Explain: \_\_\_\_\_

- I wish to Terminate coverage on my dependents       Dental       Vision      Date \_\_\_\_\_ of change
- Reason for Termination:       Cost
- Other Coverage
- Divorce
- Dependent       over age       not a full-time student       marriage
- Other Changes (please explain) \_\_\_\_\_

List full name of dependent(s) to be added or terminated	Soc Sec#	Date of Birth	Relationship
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Change of beneficiary: I hereby revoke any previous beneficiary designation and now designate the following beneficiary.

Last Name, First, Middle Initial

Relationship to you

Address of Beneficiary

City

State

Zip

Signature of Employee

Date of Signature