

UNION ENROLLMENT CHANGE REQUEST FORM

Name: _____

Daytime Phone Number: _____

Union: IBEW Local 109

IUEC Local 2

IUOE Local 399

IBEW Local 134

IUEC Local 34

Sheet Metal Workers Local 73

Change Requested (mark all that apply):

A. Address

C. Payment Method

B. Phone Number

D. Other

A. My new address is:

Street address: _____

City: _____

State: _____

Zip: _____

B. My new phone number is:

New Phone Number: (____) _____ - _____

C. Please change my payment method as follows:

Charge my premium to a new credit card. (Select Visa or Mastercard)

Visa: _____ - _____ - _____ - _____ exp: ____/____

MC: _____ - _____ - _____ - _____ exp: ____/____

Please do a monthly bank draft. (Select Checking or Savings)

Checking: Routing # _____ Account # _____

Savings: Routing # _____ Account # _____

D. Please make another change:

Please suspend my premium payment effective*: _____

This change is due to: Unemployment Disability, illness, or injury

Please reinstate my premium payment effective*: _____

Please cancel my policy effective*: _____

Please update my wage rate to*: _____

Other: _____

Signature: _____ Date: _____

**Premium adjustments are only allowed retroactively up to 60 days. Reinstatements must be requested within 60 days of return to work or a medical questionnaire will be required to rejoin the plan. Wage rate changes will take effect on the first of the month following your request.*

Once complete, fax or mail this form to: Group Benefit Associates 773-427-6875 fax
3963 W. Belmont Ave., Suite 6, Chicago, IL 60618