Use this form to indicate changes to your member information, add or delete dependents, or cancel your coverage

CHANGE FORM

Milwaukee Drivers Health and Welfare Trust Fund
10020 W. Greenfield Ave., Milwaukee, WI 53214
Telephone 414-258-2336 • Toll Free 800-255-3340

A. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	BIRTH DATE

SOCIAL SECURITY NUMBER	HOME PHONE	WORK PHONE

B. EMPLOYEE CHANGES

1. Change Address to:

2. Change Name from: to:

C. CHANGES IN COVERAGE

1. Additions: (Check one) ☐ Birth — Other qualifying events (attach supporting documentation, including effective date) ☐ Adoption _____ ☐ Other (Describe) _____ ☐ Marriage _____

2. Deletions: (Check one) ☐ Cancel all coverage ☐ Delete dependents listed below — **Reason:** (Check one) ☐ Employee terminated ☐ Death _____ ☐ Moved outside service area ☐ Divorce _____ ☐ Employee now ineligible ☐ Dependent now ineligible ☐ Other _____

List all family members to be added, changed or deleted.
Do all dependents to be added live at the same address as employee? ☐ YES ☐ NO If no, provide dependent address below.

Change (Check one)	**First Name**	**MI**	**Last Name**	**Relationship**	**Sex**	**Birth Date**	**Social Security Number**
☐ ADD ☐ CHANGE ☐ DELETE							
☐ ADD ☐ CHANGE ☐ DELETE							
☐ ADD ☐ CHANGE ☐ DELETE							
☐ ADD ☐ CHANGE ☐ DELETE							
☐ ADD ☐ CHANGE ☐ DELETE							

D. SIGNATURE (THIS FORM MUST BE SIGNED)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the plan or any of their designees any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage.

X PER PHONE CALL

Employee Signature Date Signed

E. FOR FUND OFFICE USE ONLY

Milwaukee Drivers Health and Welfare Trust Fund

Group Number

Effective Date:	Approved by	Plan Sponsor Phone No.	Date
Termination Date:		*414-258-2336*	