Submit to:

PO Box 950
Forest Hill, MD 21050-0950

p 800.799.8785
f 410.877.2004

Legal Name: Custom Rail Employer Welfare Trust Fund
Version: CREW / CT / 0409

Adobe Reader Version 7 or later is required to complete this form. Download the FREE update at www.adobe.com

EXISTING MEMBER CHANGE/TERMINATION FORM

Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.

SECTION I. GENERAL INFORMATION

Group No. ____________ Employee Social Security No. ____________

Last Name: ____________ First Name: ____________ MI: ____________

Employer Name: ____________ Location: ____________

SECTION II. CHANGE IN EMPLOYEE INFORMATION

NEW EMPLOYEE INFORMATION

New Name: ____________ New Phone: ____________

New Address: ____________ City: ____________ State: ____________ Zip: ____________

Required Event Date: (mm/dd/yyyy)

SECTION III. CHANGE IN CURRENT COVERAGE *(subject to the plan provisions and plan options selected by your employer)*

SELECT HEALTH PLAN CHANGE

CHANGE FROM:

Employee Only EE + Spouse

EE + Child(ren) EE + Family

CHANGE TO:

Employee Only EE + Spouse

EE + Child(ren) EE + Family

Required Event Date: (mm/dd/yyyy)

SECTION IV. CHANGE IN FAMILY INFORMATION *(please complete for all persons to be covered)*

First Name & M.I. (last name if different)	Gender		DOB	F/T Student*		Height	Weight	Social Security No.
	M	F		Yes	No			
Spouse:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								

Special Enrollment Event *(The Plan Administrator may require proof of Special Enrollment Event.)*

Marriage Loss of Coverage Newborn / Adoption

Required Event Date: (mm/dd/yyyy)

* Full time students ages 19 - 24. Student certification required from accredited college. Contact the Plan Administrator for a Student Status form.

SECTION V. TERMINATION OF COVERAGE

Terminate ALL Coverage | Terminate ONLY the following coverage(s): Health Dental Vision STD

Reason for Termination of Coverage:

Termination of Employment Reduction in Hrs Death Has other Coverage Divorce/Legal Separation Other ____________

Required Event Date: (mm/dd/yyyy)

Employee Signature: ____________ Date: ____________

Employer Signature/Verification: ____________ Date: ____________