

Group Case Number: _____
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**Business Name and/or Address Change Form**

1. Current Business Name: \_\_\_\_\_  
 a. New Business Name: \_\_\_\_\_

2. Current Business (Physical) Address: \_\_\_\_\_

City	State	Zip Code	Area Code + Phone No.
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- a. New Business (Physical) Address: \_\_\_\_\_

City	State	Zip Code	Area Code + Phone No.
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- b. New Business (Mailing) Address: \_\_\_\_\_

City	State	Zip Code	Alt. Area Code + Phone No.
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3. Current Tax ID Number: \_\_\_\_\_ New Tax ID Number: \_\_\_\_\_

4. Type of Business: Corporation: , Partnership: , Sole Proprietorship: ,  
 Other: \_\_\_\_\_

5. Name of Owner(s): \_\_\_\_\_

6. Name of Group Contact or Administrator (other than owner): \_\_\_\_\_

7. Are FICA withholdings made on behalf of all employees working for your business? Yes , No

- a. If answered "No" please explain: \_\_\_\_\_

8. Has your business changed ownership or the nature of the business in any respect since you applied for this group policy? Yes , No . If answered "Yes" please explain: \_\_\_\_\_

- a. Effective date of this change: \_\_\_\_\_

9. For Change of ownership, indicate the Names of ALL employees currently working for your business (attach on another sheet of paper if needed).

- a. \_\_\_\_\_,  
 \_\_\_\_\_,  
 \_\_\_\_\_,  
 \_\_\_\_\_,

10. Do you understand and agree that only persons directly employed and actively at work on a full-time (30+ hours per week) basis in the regular business of, and compensated for services by, the Original Participating Employer are eligible for coverage; and that any misrepresentations or omissions of facts given on or with this change form may be cause for termination of coverage? Yes , No .

\_\_\_\_\_  
 Owner's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Owner's Printed Name