Group Change Form

WMC Service Corporation
Employee Benefits Administration

Phone # 800-236-5414
Fax # 608-258-3413
E-mail: ins@wmc.org

Company Name: ____

Policy #: ________________________

Your Name: ________________________

Tele. # or E-mail Address: ________________________

Date: ________________

			Termination Information *			Revision Information		
Change Reason T = Term R = Revision	**Employee Name** (If name change, add new name to the row below the old name)	**S.S. #** XXX-XX-1234	**Last Day Worked**	**Last Day of Coverage**	**Termination Reason** (optional)	**Eff. Date of Change**	**Annual Earnings****	**Other** (If EE class has changed, provide class description in this column)

* **Termination** - Premium will be billed on a daily prorated basis. Last day worked & last day of coverage are normally, but not always the same day.
** **Annual Earnings** - If earnings are expressed on an hourly basis, please indicate the # of hours worked in the "Other" column.

Please advise us ASAP of any change to your employee benefits billing or executive contacts.