**REQUEST FOR CHANGE**

Trustmark benefits beyond benefits

Trustmark Contacts:
Medical: (855) 236-6622
Rx: (877) 200-5533

Anthem

Anthem Contacts:
Dental: (877) 604-2158
Vision: (866) 723-0515

COMPANY NAME: **Walton County Board of Commissioners**

EMPLOYEE NAME: _____

SOCIAL SECURITY#: _____

Under the terms of our policy, I hereby submit to Human Resources a request for Trustmark/Anthem to make the following changes:

Effective Date of Change : _____

Reason for Change: _____

1. Change Employee Name To: _____
2. Change Employee Address To: _____

_____

4. Change Coverage Status ☐ Dependents Added ☐ Dependents Dropped

| Name | DOB | SS# | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

5. Add Coverage ☐ What Type of Coverage _____
All Coverage means Medical, Dental, Vision, Rx

6. Terminate Coverage ☐ What Type of Coverage _____
All Coverage means Medical, Dental, Vision, Rx

7. Change Location From _____ To _____

_____ _____
Signature Date

-Benefits Specialist

_____ _____
Authorized Signature & Title Date