CHANGE OF NAME and/or CHANGE OF ADDRESS
(Please Print)

Date Of Request _______________

NEW INFORMATION	PREVIOUS INFORMATION
Name: ______________________________	Name: ______________________________
Address: ______________________________	Address: ______________________________
City: ______________________________	City: ______________________________
State: _______________ Zip: __________	State: _______________ Zip: __________
Phone: (_______) ____________________	Phone: (_______) ____________________

Copy of new Social Security card **MUST** be attached for a name change.
(If due to Marriage/Divorce, would you like to change your beneficiary?
If so, please ask for the Life Insurance and/or Pension Forms to do so.)

Please Check The Following That Apply

If adding or cancelling someone from your benefit contracts, please contact Human Resources for appropriate forms and required documentation.

☐ **Health Insurance**
(Current Health Insurance Carrier)
☐ McLaren Health Advantage ☐ Blue Cross Traditional

☐ **Dental Insurance** (Delta) ______________________________

☐ **Vision** (Eyemed) ______________________________

☐ **Pension** ______________________________

Signature: ______________________________