Lucent Health

CHANGE FORM

P O Box 7020 Appleton, WI 54912 Phone: 877-236-0844 Fax: 866-542-1874

GROUP NAME: McCoy Federal Credit Union **GROUP #: B11**

EMPLOYEE INFORMATION

Social Security Number	Last Name	First Name	MI

CHANGE OF ADDRESS

Effective Date: _____

OLD		**NEW**	

ADD / TERM DEPENDENT

Effective Date: _____

Reason for Change: _____

Add or Term		Sex	Last Name	First Name	MI	Birth Date	Social Security Number
	Spouse	M/F					
	Child	M/F					
	Child	M/F					
	Child	M/F					
	Child	M/F					

CHANGE OF COVERAGE

Effective Date: _____ **Add**_____ **Drop** _____

Reason for Change: _____

CURRENT	MEDICAL PLAN	Single	Employee & Spouse	Employee & Children	Family
NEW	MEDICAL PLAN	Single	Employee & Spouse	Employee & Children	Family

OTHER

Effective Date: _____

Participant Signature: _____ Date_____

Certified By: _____ Date_____