Change of address/name form

Employer name _____

Effective date of change _____

Employee Please print legibly in blue or black ink.

SSN | Name (last, first, initial) | Date of birth | Gender

New home / mailing address | Phone (with area code)

City | State | Zip | Email address

Occupation _____ Annual salary _____ Class/bargaining unit _____

Your signature is required Address cannot be updated without your signature.

I hereby apply for coverage under the contract between the respective insurance company and my employer and AWC, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or dependent children listed on this application. I certify that my dependents and I meet all the eligibility criteria set forth in the outline or benefits and/or the Contract.

I have provided these answers as part of the application procedure required by the insurance carriers listed on the bottom of this form to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the insurance carriers will rely on each answer in making coverage and rating determinations. If the insurance carriers continue the contract with the AWC Trust and my employer after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the rate quoted, I understand that the insurance carriers will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the rate adjustment within 30 days of the date of notice by the insurance carriers. For the protection of all of our members, knowingly providing us with false, incomplete, or misleading information may result in the insurance carriers taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, the insurance carriers will have the right to collect any claims payments or other damages.

Signature _____ Date _____

Note: For any other changes to your benefits, please complete the AWC Combined Insurance Enrollment Form.

Employer: Employer to send completed form to AWC at benefitinfo@awcnet.org or fax to 360.753.0149 or mail to 1076 Franklin Street SE, Olympia, WA 98501-1346

Regence BlueShield
1800 Ninth Ave
Seattle, WA 98101

Asuris Northwest Health
528 E Spokane Falls Blvd,
Suite 301
Spokane, WA 99202

Kaiser Foundation Health Plan of Washington/Kaiser Foundation Health Plan of Washington Options Inc.
601 Union St., Suite 3100
Seattle, WA 98101

Delta Dental of Washington
9706 Fourth Ave NE
Seattle, WA 98115

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

ComPsych
NBC Tower
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322

Standard Insurance Company
1100 SW 6th Ave.
Portland, OR 97204

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124