CORESOURCE
A Trustmark Company
P.O. Box 8215 / Little Rock, AR 72221-8215

mail to:
Arkansas United Methodist
Conference Benefits Office
PO Box 2941
Little Rock, Ar. 72203-2941
Fax: 501-324-8043

CHANGE FORM

EMPLOYEE INFORMATION

EMPLOYEE NAME:	EMPLOYER NAME:
SOCIAL SECURITY NO.:	GROUP NO.: ARMET01

TYPE OF CHANGE (CHECK APPLICABLE BOX/BOXES)

- ☐ Change to Family Plan
- ☐ Change to Individual Plan
- ☐ Add Spouse / Dependents
- ☐ Change of Beneficiary
- ☐ Address Change
- ☐ Delete Spouse / Dependents
- ☐ Name Change
- ☐ Termination

COMPLETE APPLICABLE SECTION(S)

CHANGE TO FAMILY PLAN	CHANGE TO INDIVIDUAL PLAN
REASON FOR CHANGE:	REASON FOR CHANGE:
EFFECTIVE DATE OF CHANGE:	EFFECTIVE DATE OF CHANGE:

ADD SPOUSE / DEPENDENTS

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	BIRTHDATE MO / DAY / YR	SEX M / F	RELATIONSHIP TO INSURED

EFFECTIVE DATE:

DELETE SPOUSE / DEPENDENTS

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	RELATIONSHIP TO INSURED

EFFECTIVE DATE:

CHANGE OF BENEFICIARY (Give Full Name/Relationship to Employee)

FROM:

TO:

CHANGE OF SALARY

AMOUNT OF NEW SALARY:

$

ADDRESS CHANGE

NEW ADDRESS:

NAME CHANGE

CHANGE FROM:

CHANGE TO:

EFFECTIVE DATE OF CHANGE:

TERMINATION

TERMINATION DATE OF BENEFITS:

EMPLOYEE SIGNATURE

DATE

Form #30