



# Change or Terminate Form

Secure upload at: **www.ebcflex.com**  
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 Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347  
 Phone support: **800 346 2126**, 608 831 8445, M - F 8:00 - 5:00 Central  
 E-mail support: **employerservices@ebcflex.com**

Employee Benefits Corporation

## Organization Information

Organization Name

Payroll Department Signature (optional)

Date (mm-dd-yyyy)

## Account Holder Information

**Last 4 Digits of Social Security or Identification Number**  
(Required)

**Employee:** Last Name

Suffix

First Name

MI

## Change Account Holder Name

Change the Account Holder name above to the following:

New Last Name

Suffix

First Name

MI

Effective Date (mm-dd-yyyy)

## Change Account Holder Address

Change the address of the Account Holder named above to the following:

Mailing Address

Apt. No.

City

State

Zip Code

Effective Date (mm-dd-yyyy)

## Change Account Holder Coverage Type

**From:**  Single  Limited Family  Family **To:**  Single  Limited Family  Family

Effective Date (mm-dd-yyyy)

Indicate briefly, the reason for the coverage change

## Terminate Account Holder

Terminate the Account Holder named above from the plan:

Coverage End Date (mm-dd-yyyy)

Give a brief reason for Account Holder's termination from plan

**Add or remove Dependents - Next page**

**Add A Dependent**

Complete this section ONLY if coverage type is family or limited family

**Add A Dependent:** Last Name Suffix First Name MI Social Security or Identification Number

**Relationship to acct holder:**  Spouse  Child  Domestic Partner   M  F  
 Other:  Date of Birth (mm-dd-yyyy) Gender

**If Medicare Entitled, check reason:**  Aged  ESRD  Disabled   
 Medicare HICN (if entitled to Medicare)

**Add A Dependent:** Last Name Suffix First Name MI Social Security or Identification Number

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 Other:  Date of Birth (mm-dd-yyyy) Gender

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**If Medicare Entitled, check reason:**  Aged  ESRD  Disabled   
 Medicare HICN (if entitled to Medicare)

**Remove A Dependent**

Complete this section ONLY if coverage type is family or limited family

<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Remove A Dependent:</b> Last Name	First Name	Coverage End Date (mm-dd-yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Remove A Dependent:</b> Last Name	First Name	Coverage End Date (mm-dd-yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Remove A Dependent:</b> Last Name	First Name	Coverage End Date (mm-dd-yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
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