

## Name and/or Address Change Request

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN				
MAILING ADDRESS		DATE OF BIRTH			
CITY, STATE, ZIP CODE	DAYTIME TELEPHONE ( )				
Use this form to change your name and/o	or address.				
Note: If you currently receive a pension p will become effective the month after we			/ not affect your ne	xt pension. Your ch	ange(s)
Name Change					
If you are changing your name, please of change such as a copy of a marriage co			e provide legal dod	cumentation of your	name
NEW LAST NAME		FIRST NAME			M.I.
Address Change		<u> </u>	Value de la Constantina del Constantina de la Co		
If you are changing your address, pleas	e enter your nev	w address here.			
MAILING ADDRESS			TELEPHO	NE .	
CITY	EFFECTIV	/E DATE OF CHANGE			
Certification					
This form must be signed before it can be copy of his or her authorization of guard				dorser must enclose	a ≀a
APPLICANT SIGNATURE	DATE				



Rev. 5/5/10

Pr. 5/10 - 1PDF

1475 Kendale Bivd., PO Box 2560 East Lansing, Mi 48826-2560 Questions? Call 888.888.4167 Fax 517.203.2914 Submit online at www.messa.org

# **Member Change Form**

This form is designed to make any of the changes listed below. Please fill out completely, sign and return to your employer. The signed form must be submitted within 31 days of the requested qualifying event or change to ensure timely processing. Forms received after 31 days of the actual event will be effective 1st of the month following MESSA approval.

Address		nformation (Re			SSN or MESSA ID#:						
Address	CURRENT Name and Add	ress Information	*		NEW Name and Address Information						
Susta Zip Code  Cary  County	First Name	Last Name		·	<u> </u>	First Name	Lest No	ame '			
Deportant Ramilnoter: Do you need to change or update your life insurance beneficiary? You can obtain a Beneficiary Designation Form online at www.messac. celling MESSA at 888.888.4167.  hange Code(s) (check all that apply) allifying Events: Events that easily you to make changes to your coverage eutlaide of normal Open Enrollment period. Social Security Numbers are required for all dependents.  Marriage: Date of marriage:  Birth: To add a newborn complete Section 1.  Adoption: To add an enwborn complete Section 1.  Adoption: To add an enwborn complete Section 1. Provide copy of legal documents. Provide copy of Order for Purposes of Adoption: To add an adopted child complete Section 1. Provide copy of legal documents.  Sponsored Dependent: Complete Section 1 to add. There is an additional cost for this coverage and MESSA requires IRS verification.  Divorce: Date of divorce:  To delete a spouse complete, Section 1.  Cancel Variable Options: To add an eligible dependent not lated above complete Section 1.  The Changes:  Delete Dependent: To delete dependent(s) complete Section 1.  Death Coordination of Benefits: To change dental coverage complete Section 1.  Death Coordination of Benefits: To change dental coverage complete Section 1.  Cancel Variable Options: To change name other than through marriage or divorce requires legal documentation.  Cition 1: Dependents (All Information requested below is required to add a dependent)  Code:  The Code of Code of Birth  M F (mm/dd/yyyy)  Social Security # Relationship (Code Code Code Code Code Code Code Code	Address	<u> </u>				Address		· · · · · · · · · · · · · · · · · · ·			
protrant Reminder: Do you need to change or update your life Insurance beneficiary? You can obtain a Beneficiary Designation Form online at www.messa.com	City	<u> </u>	State :	Zip C	Code	City	,	State	Zip Code		
portant Reminder: Do you need to change or update your life insurance beneficiary? You can obtain a Beneficiary Designation Form online at www.messa.cc calling MESSA et 888.888.4167.  hange Code(s) (check all that apply) allifying Events: Events that qualty you to make changes to your coverage outside of normal Open Enrollment period. Social Security Numbers are required for all dependents. In Informations when Issued.  If Marriage: Date of marriage:  To add a spouse or dependent(s) complete Section 1.  Adoption: To add an adopted child complete Section 1. Provide copy of legal documents. Provide copy of Order for Purposes of Adoption: To add an adopted child complete Section 1. Provide copy of legal documents.  Sponsored Dependent: Complete Section 1 to add. There is an additional cost for this coverage and MESSA requires IRS verification Divorce: Date of divorce:  Divorce: Date of divorce:  Defendent: To delete dependent(s) complete Section 1.  Cancel Veriable Options: To dencel veriable options complete Section 2. Calrostation of non-PMK Medical requires a Member Application.  Defendent Copy of Inspections: To change dental coverage complete Section 3.  Closed Veriable Options: To change affect of the provide copy of legal documental for non-PMK Medical requires a Member Application.  Dependents (All Information requested below its required to add a dependent.)  Concert Veriable Options  Optional Short Term Disability (STD) Optional Hospital Confinement (HCI) Optional Basic Term Life (BTL) Note: If you are enrolled in Non-PAK Medical, you may not cancel BT (Information of Benefits)  Provide copy of period to add a dependent.)  Change Code:  Relationship To Member Application of Benefits  Provide copy of period by the schere source?  Note: If you are enrolled in Non-PAK Medical, you may not cancel BT (Information for PAK Medical, you may not cancel BT (Information for PAK Medical)  Provide Code:  Co	nty Daytime Phone					County Daytime Phone					
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#### BCW-4

## HHOLDING CERTIFICATE FOR CITY OF BATTL

	IF YOU RESIDE IN THI	ECITY PLACE!	דאו יהי או	HE BOX.	IF YOU RESIDE C	יםחו שעופנטנ	ALL LEVOTA			
1. Print Pull Name				Social Security No.		Office, P	tant, Dept.	Employee I	Employee ID Humbar	
<u></u>	2. Address, Number and Street			City, Townshi	p or Village where yo	ou reside		State	Zip Code	
3.	Predominant Place of Employment Print name of each city where you w employer and circle closet % of lote in sect	ork for this 1 earnings	City			2: U: 2:	dar 5% [ ] 40% [	60% 60°	100%	
	UR WITHHOLDING Check blocks which apply	Exemptions     Exemptions	13B()	OUSE	□65 & Over □Desf □85 & Over □Desf	D Disabled		numbe/ Enter total number Enter Total		
emi	IPLOYEE: file this form with your ployer, Otherwise his must withhold y OF SATTLE CREEK Income tax		nber of exen		other depr ave claimed on lines	4,5 & 8 above		6, (a) & (b)		
EN You	n your earnings without exemptions.  IPLOYER: Keep this centificate with records if the information submitted the employee is not believed to be correct and complete advise the City.	I in the bast o	the informat of my knowle	ion submitted of edge and belied	on this certificate is to Signature	ue, correct and c	omplete		·	

LINE S INSTRUCTIONS - If you work for this amployer in more than two cities or communities, print names of two cities or communities where you perform his greatest percent of your work. Circle the classit percent of total earnings for work done or services rendered in each oily or community listed.

The estimated percent of total earnings from this employer for work done or services performed within taxing cities (line 3 on other side) is for withholding purposes only. In determining lines text liability this estimate is subject to substanliation and sudit.

DEPENDENTS - To qualify as your dependent (line 6 on other side), a person (a) must receive more than one-half of his or her support from you for the year, and (b) must have less than \$1500 (Subject to Change) gross brome during the year and (c) must not be claimed as an exemption by such person's histoand or wife, and (d) must be a citizen or resident of the United States or a resident of Canada, Maxico, the Republic of Panama or the Canada Canada (d) must be a citizen or a resident of Canada. Maxico, the Republic of Panama or the Canada (d) must be such as a contract of the disease of a resident of Canada. or the Canal Zone (this does not apply to an alen child legally adopted by and living with a United States citizen abroad), and (e) must (1) have your home as his or her principal residence and be a member of your household for the entire year, or (2) be related to you as follows:

Your son or describer (including legally edopted children), grand children, stepson, stepdate/him, son-in-lese, or described-in-lese;
Your father, mother grandparent, stephather, stepmanter, before in-lese, or mother in-lese;
Your better, mother grandparent, stephather, stepmanter, held children, bother in-lese, or state-in-lese;
Your better, mother grandparent, stephather, stephather, had also, bother in-lese, or state-in-lese; You usely, mont, neghew, or nince (but only it minist by blood).

CHANGES IN EXEMPTIONS - You should file a new certificate at any time if the

number of your examptions INCREASES.

number of your examptions INCREASES.

You must file a new certificate within 10 days if the number of examptions previously- cialmed by you DECREASES for any of the following reasons:

At wife for including when you have been existing examption is shroned or legally separate.

At the wife for including when you have been existing examption is thereof departs on the contract of the support of a dependent for whom you calmed examption is these one by someone else, so that you can no looper expect to turnish more from half the support of it for year.

At the first a dependent for whan you calmed examption will extend \$1500 (Sobject to Charge) or more of locating of accompliant, such as death of a wrife or a dependent, do not affect your withholding until the next year, but require the filling of a new certificate by December 1 of the year in which death occurs.

CHARGE OF RESIDENCE - You must file a new certificate within 18 days after your designed from or to a taxing only.

effer you change your markance from or to a taxing city.

CHANGES IN EMPLOYMENT - You must file a new carlificate by December 1 of each your in Your Line 3 estimate of the percent of work done or services to be residered in cities laying an income but will change for the ensign year.



# LAKEVIEW SCHOOL DISTRICT DENTAL ENROLLMENT FORM

Eligibility/Change/Termination Report

Name (Last)	(First)	(Middle)	Sex	Birth Date	Social Securi	ty#	
Address (Street)		City		State	Zip Code		
				•			
Occupation		Hire Date	45 (A. 10)	I	Effective Date		: C.C
Section 2—Depe	ndent Information						
ame (Last)	(First)	(Middle)	Sex	Date of Birth	Relationship	Effective Date	]
					·		
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### INDIVIDUAL ENROLLMENT/CHANGE FORM

For Vision Coverage (Please Print or Type)

EMPLOYER (GROUP) NAME Lakeview School District (Option 1)	5 5 5 5	GROUP NO. 51506 0001 01 □ Teachers 51506 0001 02 □ Secretaries 51506 0001 03 □ Food Services 51506 0001 04 □ Custodial / Maintenance 51506 0001 99 □ Cobra								
EMPLOYEE LAST NAME	FIRST			MI	DATE OF BIR	ТН				
STREET ADDRESS	CIT	Υ			STATE	ZIP				
SOCIAL SECURITY NUMBER	GENDER □ Male □ Female		Single (S) Employee	+ 1 (L)	TYPE REQUESTED					
EFFECTIVE DATE OF COVERAGE OR CH	IANGE	DATE C	F HIRE							
COMPLETE THE FOLLOWING FOR ALL F	AMILY MEMBE	RS FOR	WHOM YO	U ARE R	EQUESTING COVE	RAGE				
PLEASE CHECK THIS CHANGE IS FOR: DEMPLOYEE DSP	OUSE DEPE	NDENT(S	)							
TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ C						NGE TO COBRA				
LAST NAME	FIRST NA	ME.	INITIAL	M/F	DATE OF BIRTH	STUDENT (Y/N)				
Spouse	The state of the s									
Dependent										
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Dependent										
Dependent										
ANY PERSON WHO, WITH INTENT TO DEFRAUD OR APPLICATION OR FILES A CLAIM CONTAINING A FALL HEREBY APPLY FOR ENROLLMENT FOR VISION CO	SE OR DECEPTIVE	E IS FACILI STATEME	TATING A FRA	UD AGAINS OF INSURA	ST ANY INSURER, SUBM NICE FRAUD.	NTS AN				
EMPLOYEE SIGNATURE; X	EMPLOYEE SIGNATURE: X					DATE:				
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www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C. 1200 Route 46 West Clifton, NJ 07013

Toll Free: (800) 672-7723

