

# INSURANCE CENTER

Please complete the appropriate areas for changes to your coverage.

NAME: \_\_\_\_\_ Certificate/Policy Number \_\_\_\_\_  
(Primary Member)

**1. Change Mailing Address To:**

\_\_\_\_\_ Phone# Work: (\_\_\_\_) \_\_\_\_\_  
No. Street City State Zip  
Email Address: \_\_\_\_\_ Phone# Home: (\_\_\_\_) \_\_\_\_\_

**2. Change of Dependents:** (✓ D for Delete and A for Add. Complete Enrollment Application for additions, unless newborn child within 30 days of birth).

A	D	Full Name	Sex	Age	Date of Birth
<input type="checkbox"/>	<input type="checkbox"/>	_____			
<input type="checkbox"/>	<input type="checkbox"/>	_____			
<input type="checkbox"/>	<input type="checkbox"/>	_____			
<input type="checkbox"/>	<input type="checkbox"/>	_____			

**3. Provider Network Directory - Please refer to the back of ID Cards for web site.**

Check the appropriate box:

- Please send a **Personalized** Directory.  
 Please send a **State Wide** Directory.

**4. Additional I.D. Cards**

**5. Other:**

I understand the Company may find it necessary to amend this form in order to comply with Company practices or Certificate/Policy provisions. I therefore agree that my acceptance of the Certificate/Policy, modified by my request as amended, shall constitute my approval.

Dated at \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
(City) (State)

Signature of Primary: \_\_\_\_\_ Signature of Spouse: \_\_\_\_\_

Mail to: Customer Service Department  
9151 Grapevine Highway  
P.O. Box 982010  
North Richland Hills, TX 76182-8010