Trustmark
benefits beyond benefits

Small Business Benefits

REQUEST FOR CHANGE

Complete and fax this form to us at 847.615.5885. When the change(s) has been recorded, a copy of this form will be returned to you.

Employer Group Number	Participating Employer
Name of Employee	Employee's Social Security Number – –

☐ **1. Change of Address** (Please print)

Street		
City	State	ZIP

☐ **2. Name Change** (Please print)

Former Name
New Name
Reason for Change (Correction, marriage, divorce, court order, etc.)

☐ **3. Change of Beneficiary** (Please print)

I hereby request to change the beneficiary as indicated below. Please print name(s) in full and indicate complete address.

Beneficiary	Relationship	Percentage
Name		
Address		
Name		
Address		

If there are two or more beneficiaries, the member may specify their respective shares, otherwise they will share equally. If no designated beneficiary survives, payment shall be made in accordance with the terms of the contract.

Signature

The undersigned agrees to the above changes.

Signature of Employee

Employee Address

Date

City State ZIP

Self-funded plans are administered by Star Marketing & Administration, Inc., and stop-loss insurance and ancillary coverage are provided by Trustmark Life Insurance Company

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