INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105

CHANGE FORM

Phone 806-373-5944; Toll Free 800-687-5944
Please Email to Eligibility.Fax@imsm.net using IMS Secure Email or fax to 806-373-1136

Employee's Name: ____________________ Employer: ____________________

Employee's Social Security Number: ____________________ Group Number: ____________________

CHANGE of NAME

Former Name: ____________________ New Name: ____________________

Reason for Change: Marriage ☐ Divorce ☐ Other ____________________

CHANGE of ADDRESS / PHONE NUMBER

Former Address: ____________________ New Address: ____________________

Prior Phone Number: ____________________ New Phone Number: ____________________

ADDITION or TERMINATION of DEPENDENT(S)

I wish to **ADD** or **TERMINATE** the following:

Employee ☐ ADD ☐ TERMINATE Name: ____________________ Sex __________ SS# __________

Date of Birth __________ Coverage(s) __________ Reason: __________

If terminating, is employee disabled? __________ If adding, does employee have any other coverage? __________

If yes, please provide other insurance company's: Name __________ Policy # __________ Phone # __________

Spouse ☐ ADD ☐ TERMINATE Name: ____________________ Sex __________ SS# __________

Date of Birth __________ Coverage(s) __________ Reason: __________

If terminating, is spouse disabled? __________ If adding, does spouse have any other coverage? __________

If yes, please provide other insurance company's: Name __________ Policy # __________ Phone # __________

Child ☐ ADD ☐ TERMINATE Name: ____________________ Sex __________ SS# __________

Date of Birth __________ Coverage(s) __________ Reason: __________

If terminating, is child disabled? __________ If adding, does child have any other coverage? __________

If yes, please provide other insurance company's: Name __________ Policy # __________ Phone # __________

Child ☐ ADD ☐ TERMINATE Name: ____________________ Sex __________ SS# __________

Date of Birth __________ Coverage(s) __________ Reason: __________

If terminating, is child disabled? __________ If adding, does child have any other coverage? __________

If yes, please provide other insurance company's: Name __________ Policy # __________ Phone # __________

Child ☐ ADD ☐ TERMINATE Name: ____________________ Sex __________ SS# __________

Date of Birth __________ Coverage(s) __________ Reason: __________

If terminating, is child disabled? __________ If adding, does child have any other coverage? __________

If yes, please provide other insurance company's: Name __________ Policy # __________ Phone # __________

Requested effective date of Addition / Termination: ____________________

Note: A Certificate of Creditable Coverage, Marriage Certificate, Dependent Verification Form, Adoption Papers, Divorce Decree or other documentation may be required on some requests.

CHANGE of BENEFICIARY

I hereby revoke any previous beneficiary designation and am now changing my beneficiary to:

____________________ ____________________

(Show as Mary D. Doe, NOT Mrs. John J. Doe) Relationship

I hereby request that my insurance records be updated to show the above changes and authorize any additional payroll deduction that may be needed.

____________________ ____________________

Signature Date