



Group number: \_\_\_\_\_

## Disability Change Form

Instructions: Please complete boxes outlined in **RED**

### A: Personal Information

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Marital Status:   Single   Married   Divorced   Widowed  
Gender:   Male   Female  
Sub-Group:   Specialty Composites   Waco Boom

### B: Type of Change [**MUST SELECT OPTION(S)**]

#### Name Change:

Previous Name: \_\_\_\_\_

New Name: \_\_\_\_\_

#### Address Change:

Previous Address: \_\_\_\_\_

New Address: \_\_\_\_\_

### C: Acknowledgement of Coverage and Signature

Name Printed: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature Date: \_\_\_\_/\_\_\_\_/\_\_\_\_