# PHILADELPHIA FEDERATION OF TEACHERS HEALTH AND WELFARE FUND

 **NOTICE OF CHANGE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last*PLEASE**PRINT* | Name | First |  | Middle | Social Security | Number |
| Home Address | No. and Street | City | State | Zip Code | Telephone | No. |

Reason for Change (Check Appropriate Boxes): o Above Address is my NEW Address

* To Advise That I have been married and to add the name of my spouse
* To Add name of my new born child
* To Delete the name of my spouse or child

**Provide SS# for Spouse and other Dependents**

You must notify the District directly with 30 days of this life qualifying event. Otherwise, you

will not be able to obtain coverage until the next open enrollment period. (215) 400-4630

If employee is female, give maiden name also

If applicable, if you have not already done so you must attach a copy of:

a)birth certificate *b}* marriage certificate *c)* adoption papers *d}* custody

order *e)* guardianship order *f)* death certificate *g}* divorce papers

If you wish to claim stepchildren, please send in a notarized copy of the front page of your income tax form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| List Persons To Be Added or Deleted | Check one | Relation To You (Check Column) | Date of Birth |  |
| Add | Delete |
| Spouse | Son | Daughter | Month | Day | Year |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**