

BIAW Health Insurance Program

Change Transmittal Form

I. INSTRUCTIONS:

Use this form to: a) Cancel Employee Coverage; b) Cancel Dependent Coverage, or c) Update Insurance Information. For coverage cancellation, this form must be received by the BIAW Administrator within 15 days of a participant's last day of coverage. **Do not use this form to add employees and / or dependents to your plan.** The BIAW Employee / Subscriber Application Form, signed by the employee, is required to add new employees and/or dependents to your plan.

Please submit all forms to:

**BIAW Health Insurance Program
Attn: EPK & Associates, Inc.
15375 SE 30th Place - Suite 380
Bellevue, Wa. 98007**

II. CANCEL EMPLOYEE COVERAGE

(Note: This also cancels the employee's dependent coverage, if applicable.)

To cancel employees from your plan, please provide the information noted below. Coverage will cease at the end of the month in which the participant is no longer eligible or leaves the firm. Assuming timely notification, "cancellation date" will be the first of the month following the employee's last day of work (or loss of eligibility). Contract provisions prohibit retroactive cancellation of coverage.

Name of Employee	Social Security Number	Cancellation Date	Reason for Cancellation

III. CANCEL DEPENDENT COVERAGE ONLY

To cancel an employee's dependent(s) from your plan, please provide the information noted below.

Name of Employee	Social Security Number	Dependent's Name(s)	Cancellation Date

IV. CHANGE INSURANCE INFORMATION

(Name change, correct birthdate, correct Social Security number, etc.)

Name of Employee	Social Security Number	Description of Change

V. GENERAL INFORMATION

Name of Employer: _____

BIAW Employer Number: _____

Business Phone Number: () _____

Employer's Authorized Signature: _____ **Title:** _____ **Date:** _____

Administered by: EPK & Associates, Inc.
15375 SE 30th Place - Suite 380 - Bellevue, Wa. 98007

Phone Number (Toll Free) 1-800-545-7011 or (425) 641-7762
FAX Number: (425) 641 - 8114