



ISTA Welfare Benefits Plan and Trust ("WBPT")

Change in Status Notice

| | | | |
|----------------------------|--------------------|--------------|----------------|
| Member's Social Security # | School Corporation | Group Number | Effective Date |
| | | | |

Please complete each appropriate section in its entirety. Sign and date below. **Form must be filled in with black or blue ink.**

1. Name and/or address change – Please include a copy of a marriage license, divorce decree or legal document if changing name.

| | | | | | | | | |
|-----------------------------|--------|------|------------------------|--------|------|---|--|--|
| Previous Information | | | New Information | | | <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent | | |
| Name: | | | Name: | | | | | |
| Street Address: | | | Street Address: | | | | | |
| City: | State: | Zip: | City: | State: | Zip: | | | |
| Home Telephone: () | | | Home Telephone: () | | | | | |
| Work Telephone: () | | | Work Telephone: () | | | | | |

2. Primary Beneficiary Change – Note: This will replace all current primary beneficiaries listed on the account.

| | | | | | | | |
|--|--|--------------------|-------|----------------|-------------|--|--|
| First Primary Beneficiary's Name (Last, First, MI): | | | | Date of Birth: | | | |
| Street Address: | | | City: | | State: | | Zip: |
| Relationship: | | Social Security #: | | | Percentage: | | IRS Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Second Primary Beneficiary's Name (Last, First, MI): | | | | Date of Birth: | | | |
| Street Address: | | | City: | | State: | | Zip: |
| Relationship: | | Social Security #: | | | Percentage: | | IRS Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No |

3. Contingent Beneficiary Change – Note: This will replace all current contingent beneficiaries listed on the account.

| | | | | | | | |
|--|--|--------------------|-------|----------------|-------------|--|--|
| First Contingent Beneficiary's Name (Last, First, MI): | | | | Date of Birth: | | | |
| Street Address: | | | City: | | State: | | Zip: |
| Relationship: | | Social Security #: | | | Percentage: | | IRS Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No |

3. Contingent Beneficiary Change (continued)

| | | | | | |
|---|--|--------------------|----------------|-------------|--|
| Second Contingent Beneficiary's Name (Last, First, MI): | | | Date of Birth: | | |
| Street Address: | | City: | | State: | Zip: |
| Relationship: | | Social Security #: | | Percentage: | IRS Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Third Contingent Beneficiary's Name (Last, First, MI): | | | Date of Birth: | | |
| Street Address: | | City: | | State: | Zip: |
| Relationship: | | Social Security #: | | Percentage: | IRS Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No |

4. Dependent Addition

| | | | |
|---|--|--------------------|---------------|
| Name (Last, First, MI): | | Social Security #: | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Birth: | Relationship: |
| Reason for Addition to Policy: | | | |

5. Dependent Deletion

| | | | |
|---|--|--------------------|---------------|
| Name (Last, First, MI): | | Social Security #: | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Birth: | Relationship: |
| Reason for Deletion from Policy: | | | |

Member's Printed Name: _____

Member's Signature: _____ Date: _____

Return completed form to:

ISTA Administrative Services Corporation
150 W. Market St., Suite 728
Indianapolis, IN 46204-2875

FOR ISTA FSP USE ONLY

| ASC Rep. Name | ASC Rep Signature | Date Received by ASC |
|---------------|-------------------|----------------------|
| | | |