
DIOCESE OF WASHINGTON - EPISCOPAL CHURCH HOUSE

TO: Insurance Administrator
Episcopal Church House
Mount St. Alban
Washington, DC 20016-5094

SUBJECT: Miscellaneous Change Request

DATE: ___/___/_____

Please use this form to authorize the Insurance Administrator to make the requested changes to an individual's Policy/Account. *Associated Parishes will be billed for any changes made which affect insurance policies.*

GENERAL INFORMATION:

Name of parish/individual requesting changes: _____

Effective Date of Change: ___/___/_____

REQUESTED CHANGES:

r Home Address Change to: _____

r Billing Address Change to: _____

r Name change to: _____ due to marriage on _____

r Coverage Change to: **r** Dental Only **r** Full Health Coverage
 r Single **r** Two-Person
 r Family **r** Medicare Supplement

r Other: _____

Administration/officials signature:

Name: _____

Position of employment: _____

Telephone/Email: _____

Upon completion of this form, please mail to Church House, Mt. Saint Alban, Washington, DC 20016, or email to mmanson@edow.org, or you may fax to (202) 537 – 2385. Once we receive this form, the Insurance Administrator will follow up with the individual requesting coverage.