

BCL SYSTEMS

Administrative Solutions For Business

EMPLOYEE NAME AND/OR ADDRESS CHANGE FORM

INSTRUCTIONS: Print this Form. Fill in the information, sign, date and Fax or mail the form to BCL Systems, Inc.

Employer (or former Employer) Name:	
Effective Date of this Change:	
Name of Plan Participant:	
Social Security Number or Account Number:	
List Your New Information Below:	
New Address:	
New Phone Number:	
Please Change Name to:	

By signing this form I certify that the information provided above is correct. I understand that BCL Systems, Inc. will not release this information to any other entity, unless it is required to do so for the administration of the benefit plan(s) that I and/or my family members are enrolled in. I understand that this form does not guarantee that my employer (or former employer) or the insurance carrier(s) will receive or update their records with this new information. Further I understand that I must notify the employer (former employer) or insurance carriers of these changes in the manner prescribed by each of these entities.

Plan Participant Signature*

Date

*Signature must be of covered participant, unless participant is under the age of 18.

Please Fax this Form to BCL Systems, Inc. at: (847) 516-2952 or
Mail this form to:

BCL Systems, Inc.
PO Box 307
Fox River Grove, IL 60021