



# STATE OF WEST VIRGINIA

## Active Employee Demographic Change Form

Agency Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Last four digits of SS# \_\_\_\_\_ FBMC 4-digit work location # \_\_\_\_\_

**PLEASE SELECT THE TYPE OF CHANGE:**

- Change of Address\*     Name Change\*     Phone Number\*     Email\*

\*Only the indicated demographic information will be updated, no changes to your current benefits will be made.

**CHANGE OF ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**NAME CHANGE:**

From (Former Name): \_\_\_\_\_ to (New Name): \_\_\_\_\_

**PHONE NUMBER CHANGE:**

(Former Number): \_\_\_\_\_ to (New Number): \_\_\_\_\_

**EMAIL CHANGE:**

(Former Email): \_\_\_\_\_

to (New Email): \_\_\_\_\_

**INSTRUCTIONS:** Please return this completed document to FBMC by Mail or Fax.  
Benefit Coordinator signature is required.

Benefit Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

Benefit Coordinator Signature: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

**MAIL TO:** FBMC, ATTN: Enrollment Processing  
P.O. Box 1878, Tallahassee, FL 32302  
**FAX TO:** 1.850.514.5803, ATTN: Enrollment Processing