MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT

STATE OF WEST VIRGINIA

Active Employee Demographic Change Form

EMPLOYEE NAME: _____

LAST FOUR DIGITS OF SOCIAL SECURITY # _____

AGENCY NAME: _____ FBMC 4-DIGIT WORK LOCATION #: _____

INSTRUCTIONS: PLEASE RETURN THIS COMPLETED DOCUMENT TO FBMC BY MAIL OR FAX. BENEFIT COORDINATOR SIGNATURE IS REQUIRED.

PLEASE SELECT THE TYPE OF CHANGE:

☐ Name Change* ☐ Date of Birth* ☐ Change of Address* ☐ Phone Number* ☐ Email*

*Only the indicated demographic information will be updated, no changes to your current benefits will be made. This form cannot be used for updating dependent demographic information.

NAME CHANGE: (Former Name): _____ to

(New Name): _____

DATE OF BIRTH: _____

NEW ADDRESS: _____

_____

PHONE NUMBER CHANGE: _____

EMAIL CHANGE: _____

EMPLOYEE SIGNATURE: _____

BENEFIT COORDINATOR SIGNATURE: _____

BENEFIT COORDINATOR: _____ DATE: _____

MAIL TO: FBMC Benefits Management, Inc.
ATTN: Enrollment Processing
P.O. Box 1878
Tallahassee, FL 32302

FAX TO: 1.850.514.5803
ATTN: Enrollment Processing