FBMC
BENEFITS MANAGEMENT

STATE OF WEST VIRGINIA
Active Employee Demographic Change Form

Agency Name: Marshall University

Employee Name: _____

Last four digits of SS# _____ FBMC 4-digit work location # 0471

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: Lisa Henry 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