WELLNESS TRUST
ODA MEMBER BENEFIT

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Columbus, OH 43215-1098
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Election Change Form - Add Dependent(s)

Employer Name:	
Group #:	
Subscriber Name:	Last First MI
Address:	
City, State ,Zip	

Change Effective Date:	

Indicate Reason for Enrollment or Election Change:

☐	**Due to: Birth (within last 30 days)** Date of Birth: _____ Name: _____ Gender: _____ Social Security Number: _____ ***(If you do not yet have a social security # for a newborn, please provide by phone upon receipt.)***
☐ *	**Due to: Marriage (return with Marriage Certificate)**
☐ *	**Due to Qualifying Event** *(documentation must be included)*
☐ *	**Due to: Open Enrollment (10/15 to 11/15 to be effective 1/1)**

** Submit Election Change Request with updated Personal Health Questionnaire*

Subscriber Signature :	
Date :	