WEA trust
PO Box 259537 | Madison, Wisconsin 53725-9537
800.279.4000 WEAtrust.org

Employers Group Plan Transmittal Report

Group Name: _____ **Group Number:** _____ **Completed By:** _____

Employee Name (Last, First, Middle Initial)	**Subscriber Number**	**Type of Request** **A**ddition **D**eletion **C**hange	**Reason** **L**OA* **N**ew/Re-Hire **R**esigned **T**ermination	**Date of Event**	**Last Date Worked****	**Date Coverage Ends*****	**Plan**	**If Change, please describe********

* Type of Leave of Absence – medical, paid, unpaid, worker's compensation, FMLA – don't forget to let us know if we should bill the member directly
** Last date that the employee actively worked
*** Date employer paid insurance benefits end
**** Describe Change and provide updated information – i.e. new address, new salary amount, new occupation/hours, next of kin contact if reporting a death

Signature: _____ **Date Completed:** _____

Phone Number with Extension or Email Address: _____