CEBT
Benefit by Trust

EVIDENCE OF GROUP HEALTH COVERAGE

RESET

EMPLOYEE INFORMATION

Today's Date: _____ UMR ID#:_____

Dental ID#:_____ Kaiser ID#:_____

Subscriber Name:_____

Health Coverage (*Rx Included*) ☐ Dental Coverage ☐ Vision Coverage ☐

Start Date: _____ End Date: _____

Plan Name(s); i.e. (PPO 4, Dental A, Vision B): _____

_____

Reason for Change: _____

_____

COVERAGE STATUS

Beginning ○ Ending ○

For (Check all that apply):

Subscriber ☐ Spouse ☐ Dependent Child(ren) ☐

Dependent 1	First Name	MI	Last Name
Dependent 2	First Name	MI	Last Name
Dependent 3	First Name	MI	Last Name
Dependent 4	First Name	MI	Last Name
Dependent 5	First Name	MI	Last Name
Dependent 6	First Name	MI	Last Name
Dependent 7	First Name	MI	Last Name
Dependent 8	First Name	MI	Last Name

PLAN INFORMATION:

Plan Name: **CEBT** Plan Administrator: **Willis Towers Watson**
Address: 555 17th Street, **Suite 2050 Denver, CO 80202**
Phone: **(303) 773-1373, (800) 332-1168**