

WEA TRUST—Transmittal Report

Group Name _____ Group Number _____ Completed By _____

Employee Name (Last Name, First Name)	Subscriber Number	Type of Request Deletion Change Waiving Coverage	Reason Retirement Termination Resigned Occupation or Hours Changed (*LOA, etc.)	Date of Qualifying Event	**Last Date Worked	*** Date Employment Ends Per Employer Contract/Agreement	****Date Coverage Ends	Plan (Health, Life, LTC, Vision)	Annual Salary (For Life Plans)	Continuation Rights Under Group Plan Y/N

NOTE: One Transmittal per employee

*When reporting a Leave of Absence (LOA), please include:

- Type of leave (medical, paid, medical unpaid, unpaid Sabbatical, worker’s compensation, FMLA)
- Last date worked
- Last date of board-paid premium
- Last date of FMLA

**Last Date Worked—Last Date employee actively worked

***Date employment ends per employer contract—Date by which employee is no longer considered an active employee

****Date Coverage Ends—Date group paid insurance benefits end

SIGNATURE

DATE OF COMPLETION

PHONE NUMBER

EXTENSION

E-MAIL ADDRESS