



c/o BeneSys Administrators  
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## EMPLOYEE VERIFICATION CHANGE FORM

Date \_\_\_\_\_

In order to have verification of your requested change for our files, please complete the information below and send this form back to the Fund Office. The changes will not take place until the form has been returned to our office and we have the proper authorization in writing, along with your signature.

**Participant Name:** \_\_\_\_\_

**Social Security Number / Alternative ID:** \_\_\_\_\_

**My Current Address is:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Dependent Information Changes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Participant Signature:** \_\_\_\_\_

**\*\*By signing this form, I authorize the BeneSys Office to make the following changes to my account\*\***