TMA INSURANCE TRUST

Website form

Please complete the appropriate information below to make changes.

First Name: _____ Last Name: _____
Certificate Number: _____ Email address: _____

1) I would like to **increase** my coverage. Please have an insurance advisor contact me at:

☐Ph#_____ **OR** ☐Email _____

Product I would like to discuss: ☐Life ☐BOE ☐AD&D ☐ Dental ☐Vision
☐Accident ☐ Health ☐ Hospital Indemnity ☐Critical Illness ☐ Long Term Disability

2) I would like to **decrease** my coverage.
Product: _____
Decrease benefit from _____ to _____

3) I am **terming ALL** of my TMA Insurance Trust plans as of _____.

4) I would like to **terminate** the **only** plan(s) listed below. Please indicate whether the termination is for spouse, child(ren), or family including yourself.

Product_____ Spouse Child(ren) Family

Product_____ Spouse Child(ren) Family

Product_____ Spouse Child(ren) Family

Reason for terminating: _____
We ask this only so that we may make improvements where applicable.

☐ If submitting electronically, checking this box serves as proof of signature.

Signature: _____ **Date**: _____

The completed form can be returned via mail, email, or fax to:
TMA Insurance Trust
401 W 15th Street, Ste 600
Austin, TX 78701
Email: contact@tmait.org | Fax (512) 370-1799