



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Life and Health Division

DISCOUNT ORGANIZATION MODIFICATION FORM

- ADDRESS CHANGE NAME CHANGE OFFICER/DIRECTOR OTHER
 AMENDED ARTICLES AMENDED BYLAWS WITHDRAWAL

Please provide the following information to expedite your modification:

ENTITY NAME: _____ FEIN #: _____

- MAILING ADDRESS CHANGE

MAILING ADDRESS: _____

CONTACT PERSON: _____ TELEPHONE #: _____

E-MAIL: _____

- HOME ADDRESS CHANGE

HOME ADDRESS: _____

CONTACT PERSON: _____ TELEPHONE #: _____

E-MAIL: _____

- NAME CHANGE

FROM: _____

TO: _____

- ADDING or DELETING (please check appropriate choice)

OFFICER/DIRECTOR NAME: _____ TITLE: _____

TELEPHONE #: _____

OFFICER/DIRECTOR NAME: _____ TITLE: _____

TELEPHONE #: _____

- OTHER (please be specific)

*If you run out of space, use additional forms.

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