Health Reimbursement Account Change Form

Please PRINT Clearly

Employer	Change Effective Date

Employee's First	MI	Last Name

Employee's Home Street Address	City	State	Zip	Home Phone

Birth Date	Sex	Marital Status	Employment Date

Identify Status change:

_____ Birth or Adoption of Child _____Marriage/Divorce _____ Death of Spouse or Dependent

_____ Termination or Commencement of Employment of Spouse_____ Loss of Dependent Status

Change in Employment Status (i.e. full-time to part-time) _____Other_____

Event Date and Details: (Please provide the name, date of birth and social security numbers for new dependents)

HRA Status

Change Benefit Level to: _____ Single _____ Employee +1 _____ Family or Terminate as of: _____

I certify there has been an eligible status change/qualifying event within the last 30 days and that the requested election change is consistent with such status change. I request that changes with this employee's reimbursement account should be made as indicated.

Employer's Signature: _____ Date: _____

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