



Participant Information Change Form

Company Name: _____

Employee Name: _____ Social Security #: _____

Employee ID #: _____

Please select all plans that apply:

BASIC Flex

Medical Dependent care

BASIC HRA

BASIC HSA

Effective date of change: _____ Date of Termination: _____

Change in Annual Pledge – Old Amount \$ _____ New Amount \$ _____

Change in Per Pay Amount-- Old amount \$ _____ New amount \$ _____ Effective paycheck date _____

Permanent Change Temporary Change--(number of pays the change is effective) _____

Reason for Change:

Termination of employment Layoff Unpaid FMLA Leave Unpaid Leave

Termination of Coverage due to Status Change No Longer meet eligibility

Return of Leave of Absence (is coverage being reinstated back to start of Leave? Yes No)

No longer need daycare (dependent care reimbursement only) Increase in daycare cost

Change in Level of Coverage --- (please select new level of coverage)

Single

2 Person

Family

Marriage

Birth of child/ Adoption

Date of Last Contribution: _____

Year to Date contributions withheld:

Medical Reimbursement: \$ _____ Dependent care: \$ _____ HSA: \$ _____

New Address: _____

City: _____ State: _____ Zip: _____

Name Change:

Old Name: _____ New Name: _____

Notes: _____

Employer Signature _____

Date _____

Please fax to 800-391-6562