Document Change Form HRA Plan

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Effective Date of Change: _____ Email Address:_____

Please only complete items below that you wish to have changed. If you have any questions please call 888-472-0777. We will be happy to help you.

New Company Name: _____

New Tax ID number: _____

New Benefits coordinator: _____

New Legal Representative (Owner or Officer): _____

New Plan year: _____ to _____ (must be 12 months unless running a short plan year)

(If deductible runs calendar year, and the benefit is deductible, plan year must be calendar)

Eligibility Change:

Eligibility based on health plan? ◯ Yes ◯ No If No, complete the following: (check all that apply)

☐ Age: _____ years old ☐ Service: _____ days/months ☐ Minimum hours: _____ hrs/wk

Excluded Groups: _____

HRA Benefit:

Single: $_____ 2 Person: $_____ Family: $_____ Flat Rate: $_____

Any additional changes, please give a brief description of the change(s) below:

Signature of Individual Authorized to sign on behalf of Company : _____

Name of Authorized Individual (Please Print):_____ Date: _____