HRA
Status Change Form

Date:	
Employer Name:	
Employee Name (First & Last Name)	
Social Security Number	
Date of Birth	
Daytime Phone Number ☐ *check if phone number has changed*	
Address: ☐ *check if address has changed*	Street: City: State: Zip:
Email ☐ *check if email has changed*	

Effective: _____

I want to replace the type of coverage from _____ to _____

Reason: Marriage☐ Divorce☐ Birth☐ Adoption☐ Benefit Change☐

My HRA reimbursement will now be $_____ per Plan Year. (Please indicate if this amount is to be prorated for the remainder of the Plan Year).

I certify I have had an eligible status change and request that changes in my reimbursement be made as indicated. In no event may the action be effective prior to the completion and return of this form to my employer.

Employee Signature: **Date:**

Employer Signature: **Date:**

Mail Completed Forms to: **FIRST BENEFIT ADMINISTRATORS, INC**
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