HRA Change Form

Date				
Company Name		Client TASC ID		
Employee Name		Participant TASC ID		

❑ **TERMINATION (last date of HRA coverage)**					
Date Effective					
COBRA Elected for HRA Plan?	❑ Yes ❑ No	If Yes, Effective Date		Termination Date (Last day of coverage)	

❑ **ADDRESS CHANGE/NAME CHANGE**					
Name					
Street Address					
City		State		Zip Code	

❑ CHANGE IN DEPENDENT STATUS**

Last Name	First Name	Relationship to Employee	Social Security Number*	Date of Birth*	Gender	Add or Term	Date

❑ **OTHER**			
Explain:			
Signature		Date	

** Social Security and date of birth for employees and their dependents are required for HRA reporting purposes to the Centers for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Change Forms without this required information will be returned for completion.*

*** Must provide spouse and/or dependent information if they are covered under group health plan and eligible for reimbursement under HRA. In order for any service rendered for your spouse or dependent(s) to be covered under this HRA Plan, the spouse or dependent receiving the service must be enrolled in your employer sponsored group health plan on the day the service was rendered. Some HRA Plans allow coverage under an employer sponsored group health plan offered by another employer. Check with your Benefits Advisor.*