Clarity BENEFIT SOLUTIONS

BENEFIT PLAN CHANGE APPLICATION

If you have an employee who previously enrolled in the Benefit Plan and wishes to change or cancel their terms of your agreement you must complete the appropriate sections of this form.

Company Name: _____

Employee Name: _____ **Daytime Phone:** _____

Employee ID: _____ **Email Address:** _____

Option I: DEMOGRAPHIC

Name Change: Current Name: _____

Change to: _____

Address Change: *New* Address: _____

City, State, Zip _____

Option II: TERMINATION / LEAVE OF ABSENCE

___Termination of Employment Date of Termination: _____

___Leave of Absence (FMLA; Non-FMLA; unpaid) Date of Leave: _____

Option III: CHANGE IN STATUS/ELECTION *Please make a change to my following medical HRA account*

	Election Amount *	Begin Date	Cease Election
Medical Reimbursement HRA Plan:	$_____._____	_____	Effective ____/____/_____

*For Medical election change insert the new **annual** amount

Add Dependent:
Name: _____
Date of Birth: _____
Social Security Number: _____

Remove Dependent:
Name: _____
Date of Birth: _____
Social Security Number: _____

Effective Date: _____

Reason for Change in Employee Status:
Event Code: _____ (Cannot be retro-active)

Authorization: I hereby elect the changes indicated above due to a qualified change in status

Employee Signature: _____ **Date:** _____

Employer's Signature: _____ **Date:** _____