



First Benefit Administrators

CHANGE OF STATUS FORM

DATE:
COMPANY NAME:
PARTICIPANT NAME:
SOCIAL SECURITY NUMBER:
DATE OF BIRTH:

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

Effective: _____

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.

Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Mail Completed Forms to: **FIRST BENEFIT ADMINISTRATORS, INC**
 13080 Belcher Road South, Suite A Largo FL 33773
 Phone: 727.530.4144 ♦ Fax: 727.535.3977
www.firstbenefitadmin.com