HRA – PLAN CHANGE / TERMINATION FORM

Please fill out Company Name & Location below

_____

☐ **Change in Coverage** ☐ **Termination from Coverage** **Effective Date** / /

Employee Name _____ (Coverage Continues to the end of the Month)

Dependent Name _____

OFFER COBRA? Yes ☐ No ☐ (Send another form to notify us of COBRA Election.)

If COBRA is elected, does it also apply to the HRA Benefit? Yes ☐ No ☐

Current Mailing Address _____

Please check all that apply:

Plan to Change:		Submitted to Carrier	Sent to AA to submit to Carrier	
Medical Coverage + HRA	☐	☐	☐	
Dental Reimbursements	☐	☐	☐	
Life	☐	☐	☐	
STD	☐	☐	☐	
LTD	☐	☐	☐	
FSA	☐	NA	NA	Date of last Payroll Deduction: _____

Reason for Change:

		Notes:	
☐	No Longer Employed	☐ Quit Voluntarily	☐ Terminated by Employer
☐	No Longer Eligible	☐ Reduction of Hours	☐ Voluntary Drop of Coverage
☐	Layoff or Leave of Absence		
☐	ELECTED COBRA	COBRA START DATE:	
☐	Dependent is Over Age		
☐	Birth / Adoption of Child		
☐	Marriage / Divorce		
☐	Military Leave		
☐	Deceased		

Employer Representative Signature: _____ Date: _____

Please **FAX** this form, along with appropriate Carrier Change/Term Forms, to:

800 - 861 - 8741 OR **262 - 338 – 0845**

You may also mail them to the address below.

Averill Anderson, LLC
316 S. Main Street. West Bend. WI. 53095
1.800.388.0964