GettHealth FSA/HRA

EMPLOYEE INFORMATION CHANGE FORM

PLEASE FAX TO: 717-337-2081

Please Indicate All That Apply:	**As of Date:**	**Amount:**
❑ CHANGE CURRENT NAME/ADDRESS/PHONE		
❑ ADD DEPENDENT(s)	_____	
❑ REMOVE DEPENDENT(s)	_____	
❑ CHANGE CURRENT STATUS	_____	
❑ CHANGE HCRA ELECTION AMOUNT*	_____	_____
❑ CHANGE DCRA ELECTION AMOUNT*	_____	_____
❑ EMPLOYEE TERMINATION	_____	
❑ CANCEL HCRA	_____	
❑ CANCEL DCRA	_____	
❑ CANCEL HRA	_____	
❑ CHANGE IN ANNUAL SALARY (check only if change in annual salary has resulted in going above or below $25,000)	_____	

GROUP NAME: _____ **GROUP ID#:** _____

SOCIAL SECURITY # **EMPLOYEE NAME:**

_____-_____-_____ _____ _____ ___

LAST FIRST MI

DATE OF BIRTH: _____/____/_____ **DATE OF HIRE:** _____/____/_____

ADDRESS:_____

_____

CITY:_____ **STATE:**_____ **ZIP CODE:** _____

PHONE NUMBER: (_____)_____ **STATUS:** ❑ SINGLE ❑ NON-SINGLE

DEPENDENT INFORMATION:

Name: _____ **SSN:** _____ **DOB:** _____

Name: _____ **SSN:** _____ **DOB:** _____

Name: _____ **SSN:** _____ **DOB:** _____

EMPLOYEE SIGNATURE: _____

EMPLOYER SIGNATURE (ONLY REQUIRED IF TERMINATING EMPLOYEE):

_____

***Election Amount Changes can only be made in the following events:**

- change in employee's legal marital status
- change in number of dependents
- change in employment status
- dependent satisfies or ceases to satisfy dependent eligibility requirements
- change in residence
- commencement or termination of adoption proceedings