

HR Concepts, LLC

"Your Third Party Administrator of Choice"

Change of Status Form For Employer

Part I. Employer Information/Address (Please check if this is a new address)

Employer Name: _____ TIN # _____-_____-_____
Mailing Address: _____ City: _____ St.: _____ Zip: _____
Street Address: _____ City: _____ St.: _____ Zip: _____
Telephone: _____ POC Name: _____ Title: _____

Part II. Employee Information/Address (Please check if this is a new address)

Employee Name: _____ SS # _____-_____-_____
Mailing Address: _____ City: _____ St.: _____ Zip: _____
Street Address: _____ City: _____ St.: _____ Zip: _____
Telephone: _____ Start Date: _____ Terminated Date: _____ Eligible: YES / NO
Cobra Qualifying Event: _____

Part III. Plan Information

Original Effective Date: _____ Plan Year: _____ Short Plan Year: Yes / No
____ Premium Only Plan Effective Date: _____
____ Health Insurance ____ Dental Insurance ____ Vision Insurance ____ Other _____
____ Election Rollover each year: Yes / No ____ Negative Election: Yes / No
____ Flexible Spending Accounts Effective Date: _____
____ Health Care Reimbursement Accounts
Maximum Election: _____ Minimum Election: _____ ER Contribution: _____
____ Dependent Care Reimbursement Accounts
Maximum Election: _____ Minimum Election: _____ ER Contribution: _____
____ Cash Back In lieu of Benefits: Yes / No (Describe The Cash Back Benefit)

Eligibility:

Premium Only Plan Hours: _____ Length of Service: _____
Health Care Accounts Hours: _____ Length of Service: _____
Dependent Care Accounts Hours: _____ Length of Service: _____
How Many Employees are Eligible: _____ Total Number of Employees: _____

Payroll Information:

P/R Cycle: _____ # of P/R This Year: _____ # of P/R Next Year: _____ 1st P/R Reduction Day: _____

Part IV. Employer Signature

Employer Signature: _____ Title: _____ Date: _____



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