nyhart

8415 Allison Pointe Boulevard
Suite 300
Indianapolis, IN 46250

- EMPLOYEE CHANGE FORM -

(317) 845-3539
(800) 284-8412
FAX: (888) 887-9961

Employer: _____

Employee Name: _____ ☐ Check box if name has changed

Address: _____ Social Security Number: _____/_____/_____

_____

_____ ☐ Check box if new address

Unpaid Leave of Absence (check one)

☐ Sick/Disability/FMLA	☐ Date leave commenced	_____/_____/_____
☐ Workers' Comp.	☐ Date of last payroll deduction*	_____/_____/_____
☐ Personal	☐ Date returned	_____/_____/_____
☐ Other	☐ Date payroll deduction resumed*	_____/_____/_____

Termination of Employment

Last day worked _____/_____/_____

Date of last payroll deduction* _____/_____/_____

Revision of Benefit Election (check one)

_____	Marriage	Date _____/_____/_____
_____	Divorce, Legal Separation or Annulment	Date _____/_____/_____
_____	Birth, Adoption, or Placement for Adoption	Date _____/_____/_____
_____	Death	Date _____/_____/_____
_____	Change in work schedule of spouse or child (leave, layoff, strike, full-time to part-time, or part-time to full-time)	Date _____/_____/_____
_____	Termination of spouse's or child's employment	Date _____/_____/_____
_____	Commencement of spouse's or child's employment	Date _____/_____/_____
_____	Significant change in spouse's insurance coverage	Date _____/_____/_____
_____	Change made during spouse's or child's open enrollment period	Date _____/_____/_____
_____	Spouse, child or employee now ineligible for other coverage	Date _____/_____/_____
_____	All covered dependents became ineligible for this coverage	Date _____/_____/_____
_____	Court order to cover child (employee or former spouse); to drop child, must prove now covered under ex-spouse's plan	Date _____/_____/_____
_____	Employee, spouse or child eligible or ineligible for Medicare or Medicaid	Date _____/_____/_____
_____	Employee, spouse or child moved into or out of HMO's or PPO's service area	Date _____/_____/_____
_____	Change in rate charged by dependent care provider (as long as provider is not a relative	Date _____/_____/_____
_____	Change in dependent care provider	Date _____/_____/_____
_____	Child has become ineligible for CHIP (Hoosier Healthwise in Indiana)	Date_____/_____/_____

New reductions will be: Health FSA $_____ Dependent Care FSA $_____

Effective with pay of * _____/_____/_____

I certify the above information is complete and correct. My benefit election and salary reduction agreement will remain in effect regarding benefit coverages not listed above.

Employee Signature _____ Date _____

Authorized Representative _____ Date _____

*Please indicate actual pay date, not end of pay period.

Rev. 03/11