PRIMEPAY®

Reset Form | Email to Employer

Office Use Only	
Date Processed:	/ /
Processed by:	Client #:

PrimeFlex—(877) 769-3539

Participant Change of Information/Status Form

To be completed by employee and given to employer.

Effective Date of Change: _____

Current Employee Information (Please print clearly)

Name: (Last, First, Middle)	SSN:	Date of birth:
Employer:		

I participate in a (check all that apply):	☐ HRA	☐ FSA	☐ LPFSA	☐ DCA	☐ TRN	☐ PKG	☐ PRA

If you have a change in status, please indicate below.

☐ Marriage	☐ Divorce	☐ Birth	☐ Death	☐ Adoption	☐ Spouse Employment	☐ Eligibility of EE/Dependent
☐ Other:	Please identify the documentation used to verify this qualifying event:					

Type of Account	Per Pay Deduction	New Per Pay Deduction	Type of Account	Per Pay Deduction	New Per Pay Deduction
	$	$		$	$

☐ **I would like to change my employee demographic/dependent information to the following.**

Name: (Last, First, Middle)	Work #:	Home #:
Street:	City:	State: Zip:
Employer:	Email	

Please select the coverage elected with your employer: ☐ Single ☐ EE + Spouse ☐ EE + Child/Children ☐ Family

Add/ Delete	Card* Y/N	Beneficiary Name[5]	Relationship Code[1]	Beneficiary SSN	Date of Birth	Sex[2]	ESRD[3] Y/N	HICN[4]

1—Relationship
01=self/policyholder
02=spouse or common law spouse
03=child
20=domestic partner
04=other
*if applicable

2—Sex
0=unknown
1=male
2=female

3—ESRD End Stage Renal Disease-Permanent kidney failure requiring dialysis or a kidney transplant.

4—HICN Health Insurance Claim Number (Medicare ID)-This is required if SSN is not provided or if the active covered individual is under 45 years old and is entitled to (covered under) Medicare due to ESRD or a disability.

5—Name-Report the name as it appears on the individual's SSN or Medicare Card.

Employer: Please verify the information is correct and sign off below. Forward this form along with copies of supporting documentation to PrimeFlex in one of the following ways:

For HRA's Only 877.6FAX.HRA primeflexhra@primepay.com **For All Others** 877.6FAX.FSA primeflex@primepay.com

The undersigned participant certifies that all information pertaining to a change in information and/or status is correct and wishes for the above deductions to take place as of the "Effective Date of Change." The undersigned also certifies that all supporting documentation is original and has not been altered in any way.

Employee Signature: _____ **Date:** ____/____/____

Employer Initials: _____