benecaid®

# HSA Employer Change Form

**Send to:**
**Attention: Changes**
**185 The West Mall, Suite 800**
**Toronto, Ontario M9C 5L5**

**Fax: 1-877-797-7449**

**Email: changes@benecaid.com**

**Plan Administrator:** Please complete and sign section 1. Complete changes in sections 2 - 4 where applicable. Submit to Benecaid.

**1. GROUP**

| Company Name: | | Group Number: |
|---|---|---|
| Plan Administrator Name: | Signature: | Date Signed: YYYY MM DD |

**2. GROUP CHANGE**

| Effective Date: YYYY MM DD | New Company Name (if applicable): | |
|---|---|---|
| Street Address: | Unit #: | PO Box: |
| City: | Province: | Postal Code: |
| Telephone: | Fax: | |

**3. EMPLOYEE TERMINATION**

| Client ID | Last Name | First Name | Effective Date |
|---|---|---|---|
| | | | YYYY MM DD |
| | | | YYYY MM DD |
| | | | YYYY MM DD |
| | | | YYYY MM DD |
| | | | YYYY MM DD |
| | | | YYYY MM DD |
| | | | YYYY MM DD |
| | | | YYYY MM DD |

**4. EMPLOYEE CONTRIBUTION CHANGE**

| Client ID | Last Name | First Name | New Net Contribution | Effective Date |
|---|---|---|---|---|
| | | | | YYYY MM DD |
| | | | | YYYY MM DD |
| | | | | YYYY MM DD |
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