



## Client Contact Change Form

**Authorized Contact** - The below plan representative(s) are authorized to provide direction and approval on behalf of the plan sponsor and plan administrator. In addition, they will be provided with system access allowing them to perform various tasks including viewing participant level information, generating reports and initiating account funding.

### Products

COBRA      FSA/HRA/HSA/PKG/TRN

### Contact #1

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Agency Name (if applicable): \_\_\_\_\_

Relationship to employer:      HR      Accounting      Agent

Access to provide (Please check all that apply):      Invoicing      Reports      Portal Access

Status Change:      Add      Term      Update

### Contact #2

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Agency Name (if applicable): \_\_\_\_\_

Relationship to employer:      HR      Accounting      Agent

Access to provide (Please check all that apply):      Invoicing      Reports      Portal Access

Status Change:      Add      Term      Update

### Access Level

Single Employer      Employer Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Multi-Employer (Please complete page 2)

### Authorized Employer Requesting Access

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



**Note:** Requested contact changes will not be implemented until phone verification is completed with the designated contact(s) on record.

**Authorized Admin Phone Verification**

Admin Name: \_\_\_\_\_ Verification Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Completed by (Print Name): \_\_\_\_\_

| Employer Name | Tax ID |
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