

Employer Change Form

Adminplex Resource Services Inc.
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Employee's Name:	
Policyholder (Employer Name):	
Policy Number:	Certificate Number:

Transfer:	
Effective Date of the Transfer (mm/dd/yyyy):	
From:	To:
Division Number:	Division Number:
Class Number:	Class Number:
Department Number:	Department Number:

* please note that if the employee is transferring from a Life Only class to a class with Health and/or Dental benefits, a new enrolment form must be filled out.

Employment Information Changes:
Effective Date of the Change (mm/dd/yyyy):
Salary Basis (hourly or annually):
Salary: \$
Hours per Week:
Occupation/Title:

Termination of Benefits:
Effective Date of Termination (mm/dd/yyyy):
Reason: <input type="checkbox"/> No Longer Employed
<input type="checkbox"/> No Longer Qualifies Based on Hours Worked
<input type="checkbox"/> Transferred to a Different Facility
<input type="checkbox"/> Other: _____

If any changes need to be made to the employee's benefits, such as adding dependents to the plan, beneficiary changes, address changes, etc. please have the employee fill out an Employee Benefit Change Form, and send it to the address on the form.

 Signature of Home Administrator or General Manager

 Date Signed (mm/dd/yyyy)