# FSA/HRA ENROLLMENT / UPDATE FORM
## TRISTAR BENEFIT ADMINISTRATORS (TBA)

Company: _____ Group No: _____ Loc/Dept: _____ Month/Year: _____

Submitted By: _____ Phone #: _____

**NEW EMPLOYEES**

Please list each new plan participant. **AN ENROLLMENT FORM MUST BE ATTACHED FOR EACH NEW PARTICIPANT**.

| Coverage Effective Date | Last Name | First Name | MI | Social Security Number | | | Dept / Location |
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**CHANGE IN COVERAGE / ENROLLMENT INFORMATION** (2)

Please list each employee who is changing any piece of enrollment information (location change, marriage, divorce, new dependent, life volume change, new name, address, etc.) **PLEASE ATTACH AN ENROLLMENT FORM NOTING THE CHANGED INFORMATION.**

| Change Effective Date | Last Name | First Name | Social Security Number | | | Reason for Change (1) (Required) |
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**TERMINATIONS** (2)

Please report terminations regularly to avoid payment of ineligible claims. Insurance carriers and TBA allow up to three months credit for retroactive terminations.

**For COBRA services, provide a list of the benefits elected, along with the current home address, enrolled spouse/dependent names & dates of birth.**

| Med/Den Plan Term Date | Flex Plan Term Date | Last Pay Date of a Flex Contribution | Last Name | First Name | Social Security Number | | | Reason for Change (1) (Required) **COBRA Election - List plans (e.g. Medical, Dental) Terminating** |
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(1) Divorce, Death, Loss of Dependent Status, Termination of Employment, COBRA, Voluntary Coverage Termination, etc.

(2) Please be advised that if employee premiums are paid pre-tax, the Pre-Tax / Flexible Benefit Plan Document should be consulted for compliance with Federal Section 125 regulations, (e.g. when a person can discontinue enrollment in a plan).

Please return this form to: TBAeligibility@tristargroup.net or fax to: 515-453-2354