FSA/HRA Data Change Form

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Phone Number (_____) _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Item to Change	From	To
☐ Name		$
☐ SSN/Employee ID		$
☐ Address		$
☐ Other _____		$

Participant Authorization

By submitting this form I authorize these changes.

Upon completion I will return this form to my Employer/Human Resources Department.

Participant Signature: _____ Date: _____

Employer Authorization

Please make these changes in your Human Resources and Payroll Departments

Lifetime Benefit Solutions must receive these changes through your standard data exchange process (ie. Enter changes on the Website, send changes in your next payroll file, etc.)

Employer Signature: _____ Date: _____

Reminder to Participant: Please be sure to return this form to your Employer / HR Department (not directly to Lifetime Benefit Solutions). Your Employer will forward to Lifetime Benefit Solutions once their systems have been updated.