

## EMPLOYER

### Change Employee Benefit Level and Classification

**Use this form to (indicate changes being made):**

- Change Company Health Spending Account Levels for any or all Employee Classifications
- Change Employee Classification for Individual Employees

**Note:** Changes in marital or dependent status that affect an employee's benefit level require inclusion of "Employee Change Personal Information" form which is completed by the Employee.

**COMPANY NAME** \_\_\_\_\_

#### COMPANY HEALTH SPENDING ACCOUNT ANNUAL LEVELS

Please indicate any changes to the annual Health Spending Account level you wish for each classification of employee. If you want differing benefit levels for employees with or without dependents, please indicate the amount in the appropriate column. Otherwise, the same benefit level will apply to all employees in each classification whether they have dependents or not.

Employee Classification	With Dependents	Without Dependents	Benefits will be set annually as per our Compensation and Benefit Plan
Executive	\$ _____	\$ _____	<input type="checkbox"/> Yes
Senior Management	\$ _____	\$ _____	<input type="checkbox"/> Yes
Full Time Employees	\$ _____	\$ _____	<input type="checkbox"/> Yes
Part Time Employees	\$ _____	\$ _____	<input type="checkbox"/> Yes
Hourly Staff	\$ _____	\$ _____	<input type="checkbox"/> Yes
Commissioned Staff	\$ _____	\$ _____	<input type="checkbox"/> Yes
Other _____	\$ _____	\$ _____	<input type="checkbox"/> Yes

#### INDIVIDUAL EMPLOYEE CLASSIFICATION CHANGES

Name (First Name, Initial, Last Name) and Effective Date of Change (Month, Day, Year)	Classification	Participating in Compensation and Benefit Plan
Name _____ Date Effective _____	<input type="checkbox"/> Executive <input type="checkbox"/> Sr. Mgmt. <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Hourly <input type="checkbox"/> Commission <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes
Name _____ Date Effective _____	<input type="checkbox"/> Executive <input type="checkbox"/> Sr. Mgmt. <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Hourly <input type="checkbox"/> Commission <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes
Name _____ Date Effective _____	<input type="checkbox"/> Executive <input type="checkbox"/> Sr. Mgmt. <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Hourly <input type="checkbox"/> Commission <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes
Name _____ Date Effective _____	<input type="checkbox"/> Executive <input type="checkbox"/> Sr. Mgmt. <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Hourly <input type="checkbox"/> Commission <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes

#### AUTHORIZATION

Name and signature of authorizing officer (must be signed).

Name \_\_\_\_\_ Position/Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_