

## **Employer Change Form Salary/Class**

Send to:

Email: claims@healthrisk.ca Fax: (403) 236-9420 Mail: 50, 12221 - 44th Street SE Calgary AB T2Z 4H3

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Plan Administrator: Please complete and sign section 1. Complete Section 2 and return to Health Risk Services.

1. GROUP INFORMATION						
Company Name:				Group Number:		
Plan Administrator Name:		Signature:		Date Signed:		
2. EMPLOYEE SALARY AND / OR CLASS CHANGE						
Client ID	Last Name	First Name	New Sala	ry	New Class	Effective Date