Health Risk Services Inc.

EMPLOYER CHANGE FORM

Individual employee changes

Submit to: info@healthrisk.ca | Fax: (403) 236-9420

Complete applicable sections. Dates: YYYY-MM-DD.

1. GROUP INFORMATION & EFFECTIVE DATE

Company name

Group number

Plan administrator name

Email / telephone

Effective date of change

2. EMPLOYEE INFORMATION & CHANGE TYPE

Client / certificate ID

Last name

First name

- ☐ Salary
- ☐ Class
- ☐ Employment status / hours
- ☐ Division / location
- ☐ Leave of absence
- ☐ Maternity leave
- ☐ Parental leave
- ☐ Return to work
- ☐ Termination
- ☐ Retirement
- ☐ Temporary layoff
- ☐ Rehire / reinstate

3. SALARY, CLASS & EMPLOYMENT DETAILS (IF APPLICABLE)

New salary / earnings ($)

Pay basis (e.g., annual / hourly)

Hours per week (if hourly)

Current class

New class

Employment status: current to new

Division / location: current to new

Occupation / job title (if changed)

4. LEAVE, RETURN TO WORK OR END OF EMPLOYMENT

Last day worked

Leave start date

Expected return date

Actual return / rehire date

Employment termination date

Requested coverage end date

Coverage during leave: continue / end / confirm with HRS

Reason / coverage instructions (no medical details)

Coverage continuation and end dates are subject to plan terms and applicable requirements.

5. EMPLOYER AUTHORIZATION

I confirm the information submitted is accurate and I am authorized to request these changes.

Authorized name / title

Signature (sign after printing or electronically)

Date signed