Employer Name _____ File # _____

Signature _____ Date Signed _____
Employer Representative Completing this Form

REPORT OF CHANGES

- Please be sure to sign. Unsigned change forms cannot be processed.
- Please notify CBSA promptly of terminations (limit of 30 days credit allowed)
- Send an application form for all new employees or additions of dependents
- Include the address of terminated dependents

		TERMINATION OF EMPLOYEE COVERAGE			OTHER CHANGES (including Dependent Deletions			CBSA USE ONLY!	
PRINT EMPLOYEE NAME AND ADDRESS	SOCIAL SECURITY NUMBER	LAST DAY WORKED	REASON FOR TERMINATION	EFFECTIVE DATE OF TERMINATION	REQUESTED CHANGE • Name/Address Change • Reduced Hours	• Coverage Changes • Student Status • Marital Status • Newborn	REQUESTED EFF. DATE OF CHANGE	EFFECTIVE DATE OF CHANGE	DATE PROCESSED & INITIALS

FOR PROMPT HANDLING PLEASE FAX
01099315-0305

Fax Transmittal Memo # of pages

To Eligibility Dept. From _____
CBSA _____ Co. _____
Phone # _____
Fax # 952-593-3779 Fax # _____

CORPORATE BENEFIT SERVICES OF AMERICA, INC.
PO Box 5117
Hopkins, MN 55343-5117
email: enroll@cbsainc.com