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Health Reimbursement Arrangement Change in Employee Contact Information

Check any and all boxes that apply:

☐ Address Change ☐ E-Mail Change ☐ Phone # Change ☐ Name Change

Change Effective: _____

Address	City	State	Zip

Change Effective: _____

FORMER NAME of <input type="checkbox"/> Participant/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>
NEW NAME of <input type="checkbox"/> Participant/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>

Change Effective: _____ New Phone Number: _____

Change Effective: _____ New E-Mail Address: _____

I authorize EBC to make the changes designated above to my HRA account records.

(Signature)

Date: _____