Account Change

Skip this form! Log in at **hraveba.org** and submit your account change online.

SUBMIT COMPLETED FORM TO:

forms@hraveba.org | Fax: (206) 577-3020 | HRA VEBA Plan, PO Box 80587, Seattle WA 98108

I WANT TO CHANGE MY: (check all that apply)

- ☐ **Contact information** - *complete sections 1 and 3*
- ☐ **Legal spouse/dependent information** (add or update) - *complete sections 1, 2, and 3*
- ☐ **Name** - *complete sections 1 and 3*

1 UPDATE PARTICIPANT CONTACT INFORMATION | CHANGE NAME

ACCOUNT NUMBER or SSN ____ DATE OF BIRTH MM / DD / YYYY ____

LAST NAME ____

FIRST NAME ____ M.I. ____

HAVE YOU PREVIOUSLY SEPARATED OR RETIRED FROM THE EMPLOYER THAT MADE/IS MAKING CONTRIBUTIONS TO THIS ACCOUNT?

- ☐ YES
- ☐ NO

DATE OF SEPARATION OR RETIREMENT MM / DD / YYYY ____

EMPLOYER NAME ____

ARE YOU OR HAVE YOU EVER BEEN, ENROLLED IN MEDICARE PART A OR PART B?

- ☐ YES
- ☐ NO

NAME EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or MEDICARE CARD ____

MEDICARE ID NUMBER (HICN) ____ PART A EFFECTIVE DATE ____ PART B EFFECTIVE DATE ____

☐ **CHECK HERE IF YOUR PHONE NUMBER, EMAIL, OR MAILING ADDRESS HAS CHANGED. PLEASE PROVIDE UPDATES BELOW:**

AREA CODE and PHONE NUMBER ____ EMAIL ADDRESS (use home or personal email address) ____

MAILING ADDRESS ____ CITY ____ STATE ____ ZIP ____

☐ **E-COMMUNICATION: Please check the box and enter your email address above to sign-up for e-communication.**

E-communication is fast and convenient. Electronic documents may include your Plan Summary, participant account statement and explanation of benefits (EOB) notifications, and general communication. If you are electing e-communication, please note that after logging in to your account at **hraveba.org**, you (1) may withdraw your consent for electronic documents at any time without charge by updating your account preferences; (2) will be able to view and print copies of electronic documents (you may request paper copies at no charge by contacting the customer care center); and (3) can update your email address on file by updating your personal information. To access electronic documents, you will need a copy of Adobe Acrobat Reader software loaded on your computer. You can download and install a free copy at www.adobe.com. Documents provided electronically will not be mailed via U.S. Mail.

2 ADD/UPDATE LEGAL SPOUSE OR DEPENDENT INFORMATION

Your legal spouse and dependent(s) are eligible for coverage under this plan. **Federal law requires the Plan to have on file the full name, Social Security number, gender, and date of birth of all covered individuals.** You may cancel legal spouse and dependent coverage only in the event of a divorce or legal separation, by submitting a **COBRA Event Notice** form. Forms are available after logging in at **hraveba.org** or by request from the customer care center. List any additional dependents on an attached sheet of paper.

FIRST NAME	M.I.	LAST NAME	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LEGAL SPOUSE			☐ Male ☐ Female		
DEPENDENT 1			☐ Male ☐ Female		
DEPENDENT 2			☐ Male ☐ Female		

3 REQUIRED PARTICIPANT SIGNATURE AND CERTIFICATION

I hereby certify that the information provided on this form is true and correct. With respect to information submitted on behalf of qualified dependents, I hereby certify that each person is a qualified dependent as defined under the terms of the Plan. I acknowledge and understand that any information submitted fraudulently could result in my termination from the Plan and/or other legal action.

Your handwritten signature is required; e-signatures are not acceptable.

X ____

PARTICIPANT SIGNATURE ____ DATE MM / DD / YYYY ____ PHONE NUMBER WHERE I CAN BE REACHED ____

QUESTIONS? 1-888-659-8828 | customercare@hraveba.org | hraveba.org