



# Client Change Form

Please select from the following categories to submit your change.

Client ID: \_\_\_\_\_

Company Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Type of Change(s):

- Name Change       Contact       Division/Department  
 Address Change       Worksite Location       Other

### NAME CHANGE

New Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

DBA: \_\_\_\_\_

### WORKSITE LOCATION: ADDITON OR CHANGE

New Address: \_\_\_\_\_ Effective Date: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### ADDRESS CHANGE

New Address: \_\_\_\_\_ Effective Date: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Authorized Contact

Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Authorized Contact

Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### I would like to learn more about:

Health Insurance <input type="checkbox"/>	401K <input type="checkbox"/>	Ancillary Benefits <input type="checkbox"/>
Vision and Dental <input type="checkbox"/>	Bookkeeping <input type="checkbox"/>	Employee Portal <input type="checkbox"/>

Authorized Signature: \_\_\_\_\_ Authorized Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

Integrity Signature: \_\_\_\_\_ Date: \_\_\_\_\_