ERISA CHANGE FORM

Submit this completed form and all required materials via one of the following methods.	Online	Mail
	Sign into your account at cdaclient.basiconline.com and go to *Support › Contact Us* and attach to a support request.	PO Box 14015 Madison, WI 53708-0015

CLIENT / EMPLOYER INFORMATION

Employer Name		BASIC Employer ID (12-digit)	
Contact Name		Contact Phone	

BENEFIT PLAN INFORMATION

Anticipated number of enrolled employees as of the first day of your new Plan Year (including those on COBRA)	☐ 1-99 ☐ 100 or more
Are you considered an Applicable Large Employer (ALE) under the Employer Shared Responsibility provision of the Affordable Care Act (ACA) and are you currently tracking employee hours to determine if any variable hour, part-time, or seasonal employees are "full-time" employees for purposes of health plan eligibility?	☐ Yes ☐ No
Upon renewal, what will be the status of your Group Health Plan offered to employees?	☐ Grandfathered ☐ Non-Grandfathered

☐ **NO changes to benefit plans.**

Or detail changes to benefit plans below:

Change Codes

(1) Change of Carrier
(2) Change of Contract Period
(3) Change of Insured Status
(4) Add New Benefit
(5) Cancel Existing Benefit

	Change Code	Details *(include full carrier name, if different)*	Insured Status^	Effective Date
Health				
Dental				
Vision				
Life *(employer-paid)*				
AD&D *(employer-paid)*				
Voluntary Life				
Voluntary AD&D				
Dependent Life				
Dependent AD&D				
STD				
LTD				
Wellness				
EAP				
Stop Loss *				
Voluntary Products				
Other *				

** Confirm with your benefits advisor that these are Employer Sponsored Plans subject to ERISA.*

^ Fully-Insured or Self-Insured

AUTHORIZATION

Name _____ Email _____

Signature _____ Date _____