Change of Status Form

Section I - Employee Information

Employer Name:

Employee Name: | Social Security #:

Check if new Address ☐ | Address: | City: | State: | Zip:

Section II - Reason for Change of Election

****Generally changes must be made within 30 days of event****

Please note, the qualifying event must be permitted in your Section 125 Plan Document and summary plan description (SPD).

☐ **Gain of Spouse / Dependent** (Attach documentation)

___ Marriage ___ Adoption
___ Birth ___ Court Order
___ Dependent now satisfies eligibility requirements (i.e. becoming a student)

Effective date of the change: _____

☐ **Loss of Spouse / Dependent** (Attach documentation)

___ Divorce / Annulment / Legal Separation
___ Death
___ Court Order
___ Dependent no longer eligible (i.e. ceases to be a student)

Effective date of the change: _____

☐ **Change of Employee, Spouse, or Dependent's Employment Status <u>Triggering</u> Eligibility**

___ Begins Employment
___ Part-time to Full-time
___ Hourly to Salary

Change for Employee, Spouse or Dependent (circle one)

Effective date of the change: _____

☐ **Termination of Spouse's or Dependent's Employment Status Causing <u>Loss</u> of Eligibility**

___ Spouse's Termination of Employment
___ Dependent's Termination of Employment

Effective date of the change: _____

☐ **Dependent Care Election Changes**

___ Change in provider (babysitter, daycare, etc.)
___ Change in cost of current services

☐ **Leave of Absence** (Paid or Unpaid)

Date leave of absence begins: _____

Date of return: _____

☐ **Exchange Enrollment**

Effective date of the change:_____

☐ **Employee Termination or Benefit End Date**

___ Full-time to Part-time ___ Salary to Hourly

Date of Termination: _____

Benefit End Date: _____

Date of Last FSA Deduction: _____

Amount of Last FSA Deduction: _____

Date of Last HSA Deduction: _____

Amount of Last HSA Deduction: _____

☐ **Loss of Medicare Eligibility for Employee, Spouse or Dependent**

Effective date of the change: _____

☐ **Gain of Medicaid or Medicare Coverage for Employee, Spouse or Dependent**

Effective date of the change: _____

☐ **Loss of Medicaid or SCHIP Coverage**

**There is a 60-day special enrollment period for this event.

Effective date of the change: _____

☐ **Parking / Mass Transit Election Changes**

___ Change in location
___ Change in cost of current services

Section III - Change of Election Amount

Employee Election Category	**Current** Payroll Deduction Per Pay Period	**Revised** Payroll Deduction Per Pay Period	Date of Revised Deduction
FSA Health Care	$	$	
FSA Dependent Care	$	$	
Parking / Mass Transit	$	$	

This FSA change of election must be accompanied by the appropriate documentation for each of the above changes. Your employer will advise you of the approval or denial of your request for Change in Status. If your change is denied, you will generally have thirty (30) days in which to respond. If reviewed again and denied, you may pursue other rights accorded you under ERISA. I hereby elect the above changes due to a qualified Change in Status.

Date _____ **Signature of Participant** _____ **(not required for termination)**

Date _____ **Signature of Employer** _____

Revised January 2015