Change in Status Election

*(All fields are required. **Please Print!**)*

Employer Name: _____

Employee Name: _____

Employee Address: _____

Employee Social Security Number: __ __ __ - __ __ -

Plan Year_____through _____

Effective date: _____

First payroll date:

Please specify the account(s) affected by this change request:

____ FSA Health/Medical Account — My current contribution is:_____per Plan Year.

My new contribution should be:_____per Plan Year.

____ FSA Dependent Care Account — My current contribution is:_____per Plan Year.

My new contribution should be:_____per Plan Year.

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in status:

_____ Marriage

_____ Divorce, Legal Separation or Annulment

_____ Birth, adoption or placement for adoption of a child

_____ Death of my spouse and/or dependent

_____ Termination or commencement of employment by my spouse or dependent

_____ Change in eligibility due to: (1) switching from part-time to full-time employment (or vice-versa) on the part of me, my spouse or dependent or, (2) a reduction or increase in work hours

_____ I, my spouse or dependent have taken an unpaid leave of absence

_____ My dependent satisfies or ceases to satisfy the requirements for coverage

_____ Change in day care situation (cost, location, terms of contract, etc.).

Please explain: _____

_____ Other (specify): _____

The Administrator may require you to provide evidence to document the event which requires the change of election.

_____ Date _____

Employee's Signature

_____ Date _____

Plan Administrator's Signature

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