FLEXIBLE BENEFITS PLAN CHANGE IN STATUS FORM

Please Complete And Sign On Page Two

Company Name (Print) _____

Employee Information

Employee Name (Print) _____ Social Security Number _____

Address _____

Check if new address ❑ Former Name _____

PART I: Change in Status

I have had the following change in status (as defined in the Plan) since I signed the Election Form (check one):

❑ Leave of Absence and/or Layoff

Date of Leave/Layoff: ____ . ____ . ____

Date of Last Payroll Deduction: ____ . ____ . ____

Expected Return Date: ____ . ____ . ____ Will be making up contributions: ◯ Yes / ◉ No

❑ I have terminated employment.
Date of last payroll deduction: ____ . ____ . ____ Date of termination: ____ . ____ . ____

❑ I have married.

❑ I have divorced or legally separated or my marriage has been annulled.

❑ I have had a child (by birth, adoption or placement for adoption).

❑ I have had the following change in employment status which affects my eligibility for benefits

Explain: _____

❑ My spouse or dependent has had the following change which affects his or her eligibility for benefits.

Please identify which benefit(s) have been affected by this change: _____

_____

❑ I am returning from FMLA leave and elect to reinstate my election with respect to Employer's group health insurance plan [and/or the Health/Daycare Spending Account(s)].

❑ My cost for dependent care services has increased or decreased and I elect to make a corresponding change under my Dependent Care Spending Account. (Note-an election change is not permitted in this situation if your dependent care provider is your relative.)

❑ Other: I feel that I have a change in status NOT listed above.

Explain: _____

If I have a change in status as indicated above, I understand that I may change my election only if it is on account of, and corresponds with the change. For further explanation please contact your account manager.

See Other Side

PART II: Benefit Election Changes

In accordance with the change in status described above, I elect to change my benefit election under the Plan.

Please change the amount of my election as follows:	***From*** Per Pay Period	***To*** Per Pay Period
❑ Pre-Tax Insurance Premium Amount		
Medical $_____	$ _____	$ _____
Dental $_____	$ _____	$ _____
❑ Health Care Flexible Spending Account	$ _____	$ _____
❑ Dependent Care Flexible Spending Account	$ _____	$ _____

Effective Date ____ . ____ . ____ Date of first payroll deduction in which change applies ____ . ____ . ____

NEW ANNUAL HEALTH CARE FSA $ _____ (to be verified by employer)

NEW ANNUAL DEPENDENT CARE FSA $ _____ (to be verified by employer)

PART III: Participant Representations

I understand that the change in my election, as indicated above, will be effective at the time prescribed by the plan administrator. I also understand that this election may not be changed during the remainder of the plan year (ending) unless I have another change for which federal law permits me to make a new election.

I CERTIFY THAT ALL THE INFORMATION IN THIS DOCUMENT IS TRUE. I AGREE TO SUPPLY ANY ADDITIONAL INFORMATION THAT THE PLAN ADMINISTRATOR, IN ITS DISCRETION, DETERMINES IS NECESSARY TO PROCESS MY REQUEST FOR A CHANGE IN MY BENEFIT ELECTION.

Employee's Signature _____ Date ____ . ____ . ____

Human Resources Representative _____ Date ____ . ____ . ____

Note: If employee terminates we do not need their signature.

If you are faxing this form please be sure to send front and back.

CLICK HERE TO SUBMIT THIS FORM

Please Return this Form to:

Flex Administrators, Inc. 77 Monroe Center, NW, Suite 1100 Grand Rapids, MI 49503-2911

Phone: 616.456.7908 • Toll Free: 800.968.3539 • FAX: 616.454.6090 or 616.454.9862

forms@flexadministrators.com