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.

Please Return this Form to:

Flex Administrators, Inc. 3980 Chicago Drive SW, Suite 230, Grandville MI, 49418

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

forms@flexadministrators.com