Change in Status or Termination Form

Company name: _____ Company code: _____
Employee name: _____ Social Security Number: _____
Employee address: _____
Effective date of change: _____ If terminating, date of last deduction_____

Complete this form when a permitted change in status has occurred which affects your FSA election. All changes must be due to and consistent with the permitted change in status events.

As a participant in the Cafeteria Plan, I am entitled to revoke my prior benefits election and enter into a new election in the event of a permitted change in status event. I understand that the change in my benefits election must be due to and consistent with the permitted change in status events and that the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following permitted change in status:
Medical FSA election change:
☐ Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment.
☐ Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent.
☐ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.

Dependent Care FSA election change:
☐ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.
☐ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.
☐ Significant cost increase in your or your dependent's coverage.
☐ Significant curtailment of your or your dependent's coverage.
☐ Dependent care provider is replaced by another.

Health Insurance election change:
☐ Significant cost increase in your or your dependent's coverage.
☐ Significant curtailment of your or your dependent's coverage.
☐ Addition or elimination of benefit package option under your or your dependent's employer's plan.
☐ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.
☐ Change in coverage or open enrollment of spouse or dependent under other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.
☐ Judgment, decree or order including the imposition of a Qualified Medical Child Support Order.
☐ Gain or loss of Medicaid or Medicare entitlement.
☐ Entitlement to COBRA.
☐ Special requirements relating to the Family and Medical Leave Act (FMLA).
☐ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.
☐ Change in eligibility due to change in residency of the employee, spouse or dependent.

Change in Election due to Discrimination Testing:
☐ Reduction in elections to comply with nondiscrimination rules.

Please change my election(s) as follows:
Premium Only Plan: Change insurance premiums to $_____per pay period.
Medical Reimbursement: Change my annual election for my Medical Reimbursement from $_____to $_____
My new per pay period election will be $ _____effective with the_____ payroll.
Dependent Care Flexible Spending Account:
Change my annual election for my Dependent Care Flexible Spending Account from $_____to $_____
My new per pay period election will be $_____effective with the _____payroll.

Employee signature:_____ Date:_____
***Accepted and agreed to by*: Company Representative:_____ Date:_____**