



Change In Status Form

(Fill out only to request a Change in Participation during the year.)

Full Name: _____

Adding/Reinstating Benefits

Date of First Deduction: _____

Group Account No.: _____

Terminating Benefits

Employer: _____

Date of Last Deduction: _____

Instructions

1. Check the appropriate box to indicate a Change In Status or a Change in Cost or Coverage that may qualify you to change your coverage or FSA election for the Plan Year. If you are unsure if an event qualifies, please refer to your plan documents for further information.
2. Fill out a Salary Redirection Form (M-0019) to indicate the change(s) you wish to make in your Total Annual Redirected Amounts or in your participation. Changes you make may include, but are not limited to, increasing or decreasing the deduction amounts for medical/dental and/or dependent care accounts or withdrawing from participation.

Changes in Status

- Change in Marital Status Marriage Divorce or Annulment Death of Spouse Legal Separation
- Change in Number of Tax Dependents Birth Placement for Adoption Adoption Death of Dependent
- Change in Employment Status That Affects Eligibility

	You	Spouse/Dependent
Termination of Employment.....	<input type="checkbox"/>	<input type="checkbox"/>
Part-time to Full-time.....	<input type="checkbox"/>	<input type="checkbox"/>
Full-time to Part-time.....	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of Employment.....	<input type="checkbox"/>	<input type="checkbox"/>
Return from unpaid leave of absence.....	<input type="checkbox"/>	<input type="checkbox"/>
Strike or Lock-Out.....	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of unpaid leave of absence.....	<input type="checkbox"/>	<input type="checkbox"/>
Change in Worksite.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (Salaried to Hourly, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
- Change in Spouse or Dependent's Eligibility Under an Employer's Plan
 - Gains eligibility (age, student status, marital status).....
 - Loses eligibility (age, student status, marital status).....
- Change in Residence Affecting Eligibility You Spouse/Dependent

Changes in Cost or Coverage

(Note: Changes in Cost or Coverage do not allow for changes to health FSAs.)

- Significant Cost Increase of Your/Your Dependent's Coverage
- Significant Curtailment of Your/Your Dependent's Coverage.....
- Addition or Elimination of Benefit Package Option Under Your/Your Dependent's Employer's Plan
- Change in Coverage or Open Enrollment of Spouse or Dependent Under Other Employer's Plan

Please explain the event(s) marked above and describe how the requested benefit/election change is consistent with the event(s).

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

I hereby elect the participation change(s) noted on the redirection form attached and attest that the change is made on account of and conforms with the change in status or change in cost or coverage event.

Employee signature: _____ Date: _____

Accepted and agreed to by: _____ Date: _____

(Plan Administrator/Employer Signature)