Flexible Benefit Change/Termination Form

Plan Year: _____ Date of Event: _____ Employee SSN: _____

First Name: _____ MI: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: (_____) _____ Employer: _____

CHANGE IN PARTICIPATION, MID-YEAR ENROLLMENT DUE TO A STATUS CHANGE, or TERMINATION

I hereby revoke any previous authorization for the current year and authorize my employer to make the pre-tax payroll deductions, which I have indicated below. I understand that the deducted amounts will be available for the reimbursement of my qualifying expenses incurred during the calendar year from my effective date under the terms of the formal plan document. I also understand that deductions will be taken in equal amounts from each of my paychecks, but only if my pay is sufficient to cover those amounts.

If you have terminated and are rehired *within 30* days, your prior election amounts are reinstated unless another event has occurred that allows a change. If you have terminated and are rehired *after* 30 days, you may make new elections. Changes cannot be made retroactively and the mid-year election change must be consistent with the status change that affects eligibility for coverage under the plan. Please check the appropriate qualifying event below:

Change in Marital Status:

☐ Marriage ☐ Divorce or Annulment ☐ Legal Separation ☐ Death of Spouse

Change in Number of Tax Dependents:

☐ Birth ☐ Adoption ☐ Death of Dependent

Change in Employment Status That Affects Eligibility for You, Your Spouse or Dependents:

☐ Termination of employment/retirement ☐ Commencement of employment ☐ Change in work schedule, hours, or shift ☐ Hourly to salaried or salaried to hourly

☐ Commencement of unpaid leave/lay off ☐ Return from unpaid leave of absence/lay off ☐ Change in work site ☐ Strike or lockout

☐ **Judgements, Decrees or Orders**

☐ **Entitlement to Medicare or Medicaid**

Changes Specific to Dependent Care Expense Account Only:

☐ Significant increase or decrease in cost (no change can be made when provider is a relative).

☐ Addition, elimination, or reduction of your spouse or dependent's dependent care expense plan.

☐ Open enrollment of spouse's or dependents insurance plan.

Changes specific to Insurance Premium Account Only:

☐ Significant increase or decrease in cost of your insurance plan.

☐ Addition or elimination of your insurance plan.

☐ Open enrollment of spouse's or dependents insurance plan.

Please explain the event(s) marked above on which you are basing your request for a mid-year coverage change and describe how the requested change is consistent with the event.

Enter your new Annual Election Amount:

Health FSA or Limited: $ _____ Dependent Care: $ _____ Insurance Premium: $ _____

Employee Signature: ***Please SIGN and DATE completed form** Date: _____

Effective Date: _____

Employer Approval: _____ Date: _____

Change Approved: _____ Denied: _____

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