

FLEXIBLE BENEFITS PLAN CHANGE FORM

DATE _____ AGENCY # _____ SOCIAL SECURITY # _____

EMPLOYEE: _____
Please Print Last Name First Name

Pre-Tax Premiums (FSA), Medical Reimbursement Account and *Dependent Day Care Account Changes: Please check the reason that applies to your change in election and submit **DOCUMENTS** that will provide proof of this change in status. All family status changes listed apply to Pre-Tax Insurance Premiums (Flexible Spending) and Medical Reimbursement Accounts. Only status changes that are asterisked (*) apply to the Dependent Day Care Account.

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| _____ *Change in participant's legal marital status including Marriage/Divorce | _____ *Birth/Adoption/Placement for Adoption of Child |
| _____ *Legal Separation/Annulment | _____ Reduction/Increase in hours of employment by Employee, Spouse or Dependent (includes switching between part-time & full-time, strike or lock-out) |
| _____ *Termination or Commencement of employment by Employee, Spouse, or Dependent | _____ *Commencement or return from an unpaid leave of absence by Employee, Spouse or Dependent |
| _____ *Change in Dependent eligibility (attainment of age, student status, etc.) | _____ *A change in the place of residence or work of the Employee, Spouse or Dependent Employee |
| _____ Court Order (such as a qualified Medical Child Support Order) requires the employee to provide medical benefits for child(ren) | _____ Spouse or Dependent becomes entitled to Medicare or Medicaid |
| _____ *Death of Spouse/Dependent | _____ Employee, Spouse or Dependent becomes eligible for COBRA |
| _____ Significant change (as determined by Employees' Group Insurance) in the benefit plan or employer contribution. | |

The change in your election must be consistent with the Change in Family Status. *This consistency requirement is met if it results in the Employee, Spouse or Dependent gaining or losing eligibility under the Plan's health coverage or the health coverage of the Spouse's or Dependent's employer and the election change corresponds with that gain or loss of coverage.*

You must complete and submit this form along with appropriate documentation of the change to the Group Insurance Office. **The form and documentation must be received within 31 days after the Change in Family Status.** The change in election will become effective the first of the month following the receipt of the properly completed change request and appropriate documentation. Please indicate your election below:

- _____ Elect Pre-Tax Insurance Premiums
_____ *Drop Pre-Tax Insurance Premiums
_____ *Elect Dependent Day Care Account in the Amount of \$_____ per month.
_____ *Change Dependent Day Care Election Amount to \$_____ per month.
_____ *Drop Dependent Day Care Account.
_____ Elect Medical Reimbursement Account in the Amount of \$_____ per month.
_____ Change Medical Reimbursement Election Amount to \$_____ per month.
_____ Drop Medical Reimbursement Account.

Employee Signature

Date