HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT
MID PLAN YEAR ELECTION DUE TO CHANGE IN STATUS

(Please complete and return to your employer within 30 days of the relevant change in status)

SECTION 1

Name: _____ Company: _____

Social Security Number: _____ Date of the Change in Status Event: _____

Street Address: _____ City, State, Zip: _____

Date of Birth: _____

Check one of the following **"Change In Status Events"** that you have experienced:

- ☐ I am newly eligible to Participate in the Plan. My date of hire was:_____
- ☐ Change in **legal marital status** (*includes marriage, divorce annulment, legal separation, death of spouse*)
- ☐ Change in **number of tax dependents** (*includes birth, adoption, placement for adoption, death*)
- ☐ **Commencement or termination of employment** by you, your spouse or your dependent
- ☐ Change in **work schedule** (*reduction or increase in hours worked by you, your spouse or your dependent including a switch between full-time and part-time, strike, lockout, taking of or returning from unpaid leave of absence*)
- ☐ Dependent meets or ceases to meet **dependent eligibility status** (*includes reaching limiting age, losing or gaining student status, and marriage*)
- ☐ Change in the **place of residence or work** of you, your spouse or your dependent (*includes moving into or out of an HMO area*)
- ☐ **Other** (*please explain*):_____

NOTE: You may be required to submit appropriate documentation to verify the Change of Coverage.

SECTION 2

Based on the Change in Status Event(s) indicated above, I wish to change my annual election to my Health Care Flexible Spending Arrangement as follows:

$_____ Current Annual Election
(enter 0 if not previously participating)

$_____* New Annual Election

*Your new annual election can not be less than the amount of your account's year to date contributions or your year to date reimbursements

SECTION 3

I have read and fully understand the rules related to my request for a change in election. I understand that my new Agreement Form and this Change in Status Form must be completed within 30 days of the change in status event; and, the election change I have requested must be consistent with the change in status. I understand any election change will be effective on the later of the date of the change in status, or on the date I request the election change by submitting this form. I certify that the above information is true and correct, and agree to provide any necessary third-party documentation to verify the change in status event.

_____ _____
Employee Signature Date

For Employer Use Only:

Received by Employer: _____ _____
Employer Representative Signature Date

First Paydate For New Deduction Amount: _____