



Participant Change of Status Request Form

Company Information (PLEASE PRINT)

Company Name	Division (If applicable)
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Participant Information (PLEASE PRINT)

Last Name	Primary Phone
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First Name	Secondary Phone
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SSN / (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address (For Account Notifications)
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Street Address
(Check if New Address)

City	State	Zip
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If your qualifying event was incurred by a spouse or eligible dependent, please provide the following information:

Name	Relationship to Participant	Date of Birth

Change of Status No Changes

Please check the box next to your Change of Status

<input type="checkbox"/> Change in Marital Status (marriage, divorce, death of a spouse, legal separation or annulment)	<input type="checkbox"/> Change in Daycare Provider and/ or Rates (Dependent Care Reimbursement Account Only)
<input type="checkbox"/> Change in Number of Dependents (birth, adoption, or death)	<input type="checkbox"/> Leave of absence in accordance with the Family Medical Leave Act:
<input type="checkbox"/> Change in Employment and/or Eligibility of Self, Spouse or Dependent	Check one: <input type="checkbox"/> Pre-Pay Option <input type="checkbox"/> Catch-Up Option <input type="checkbox"/> Opt-Out Option <input type="checkbox"/> Pay As You Go
	<input type="checkbox"/> Other Change

Explanation: _____

Change of Election

Healthcare –Flexible Spending Account (FSA) Out-of-pocket medical, dental and vision expenses	Payroll Deduction Amount X (Number of Pays) = Annual Election \$ _____ X _____ = \$ _____
Dependent Daycare –Flexible Spending Account (FSA) Child and/or adult daycare expenses	Payroll Deduction Amount X (Number of Pays) = Annual Election \$ _____ X _____ = \$ _____

Certification

I hereby certify that the information supplied on this form is true and accurate. I understand that if I submit a false or deceptive statement, I am guilty of insurance fraud under state and/or federal law. Employee Signature _____ Date _____	<p style="text-align: center;"><i>(For HR office use only)</i></p> <input type="checkbox"/> Approved <input type="checkbox"/> Denied Effective Date : _____ HR Representative Initials: _____
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Participant Change of Status Request Form Instructions

1. **Complete all company and employee information** on the front page (please print/type)
2. **Check the box** next to the change of status you have experienced
3. **Provide an explanation** of the event if you checked *Other*
4. **Fill in the spaces** for the deduction(s) you wish taken from your pay each pay period, the number of pay periods left in the year and the total amount for the year
5. **Return this form** to your Human Resource Representative on or before the end of your change of status grace period