



# Change in Status Form

Check the appropriate boxes that apply.

- Marriage
- Divorce
- Legal Separation
- Birth
- Adoption
- Death of Dependent
- Employment
- Termination of Spouse's Employment
- Loss of Dependent Status
- Change in Day Care Provider *(Can only affect a change in Dependant Care Account)*

### Health Plan FSA (Limited Scope)

Previous Election Amount \_\_\_\_\_ Per Pay Period

New Election Amount \_\_\_\_\_ Per Pay Period

### FSA

Previous Election Amount \_\_\_\_\_ Per Pay Period

New Election Amount \_\_\_\_\_ Per Pay Period

### Dependent Care

Previous Election Amount \_\_\_\_\_ Per Pay Period

New Election Amount \_\_\_\_\_ Per Pay Period

### Major Medical

Previous Election Amount \_\_\_\_\_ Per Pay Period

New Election Amount \_\_\_\_\_ Per Pay Period

Effective Date \_\_\_\_\_

1<sup>st</sup> Payroll Date with New Deduction: \_\_\_\_\_

I hereby elect to change the following contributions as a result of my change in status:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Plan Administrator Name

\_\_\_\_\_  
Plan Administrator Signature



*Please return this form within 30 days of Change in Status to:*