Change in Status/Termination Election Form

Section 125 Cafeteria Plan (Health FSA & Dependent Care)

Complete this form when a change in status has occurred which affects your Cafeteria Plan election. All changes must be due to and consistent with the change in status.

Company Name: _____

Employee Name: _____ Employee SSN: _____

Employee address: _____ Employee Phone: _____

Effective date of change: _____ If terminating, date of last deduction: _____

As a participant in the Cafeteria Plan, I am entitled to modify my prior benefit elections and enter into a new election in the event of certain changes in status. I understand the change in my benefit election(s) must be due to and consistent with the change in status, and the change must be acceptable under the Regulations issued by Department of Treasury.

I certify that I have incurred the following change in status:

Change in Marital Status

□ Change in legal marital status including marriage, death of spouse, divorce, legal separation or annulment. (Employee may enroll as of status date if not already done so, or increase their FSA election).

Change in Number of Tax Dependents

□ Change in the number of tax dependents including birth, adoption, placement for adoption, or death of a dependent. (Employee may enroll as of status date if not already done so, or increase their FSA election).

Changes in Spouse or Dependent's Eligibility under an Employer's Plan

□ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.

□ Judgment, decree or order including imposition of a Qualified Medical Child Support Order. (Employee may enroll as of status date if not already done so, or increase their FSA election).

□ Entitlement to COBRA

Change in Employment Status that Changes Eligibility Status

□ Change in employment status, such as termination of employment. (Employee's FSA coverage ends on last day of employment).

□ Change in work schedule, such as **reduction** in hours of employment, including a switch between full-time to part-time, which makes employee ineligible for employer's benefits (based on Plan Document ruling). (Employee's FSA coverage ends on date of status change).

□ Change in work schedule, such as **increase** in hours of employment, including a switch between part-time to full-time, which makes employee eligible for employer's benefits (based on Plan Document ruling). Employee may enroll in the FSA. Effective date is the date of status change.

□ Change in work schedule, such as return from an unpaid leave of absence; FMLA. (If employee had previous FSA election, all missed FSA contributions must be made up, or coverage will remain terminated and employee can therefore make a new election; effective upon return date).

□ Change in eligibility due to change in residency of the employee, spouse or dependent. (Employee may enroll as of status date if not already done so, or increase their FSA election).

Change in Cost or Coverage (applicable for dependent care assistance account elections only)

(Employee may decrease DepCare coverage or cease election entirely, as of effective date of status change).

□ Dependent care provider is replaced by another.

□ Dependent care provider closed business.

□ Dependent care provider's services increased.

Please change my election(s) as follows:

Health Flexible Spending Account

Change my annual election for my Health FSA from $_____ to $_____.

My new per pay FSA contribution amount will be $_____ effective with the _____ payroll.

Dependent Care Assistance Plan:

Change my annual election for my Dependent Care FSA from $_____ to $_____.

My new per pay FSA contribution amount will be $_____ effective with the _____ payroll.

_____ _____

Employee Signature Date

Accepted and agreed to by:

_____ _____

Company Representative Date