

**FSA CHANGE OF STATUS FORM**  
**FSA & HRA TERMINATION NOTIFICATION**

Complete this form when a change in status occurs which affects your Premium Account, Medical or Dependent Care Reimbursement Account elections. All changes must be due to and consistent with the change in status.

Company Name: _____
Employee Name: _____
Social Security Number: _____
Employee Address: _____
<b>Actual Event Date:</b> _____
Effective Date of Change: _____ <b>(Must be after this form is signed and dated below.)</b>
Termination Date: _____ End of Coverage Date: _____ Last Pay Date: _____

As a participant in the Cafeteria Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status. I understand that the change in my benefits election must be necessitated by and consistent with the change of status and that the change must be acceptable under the Regulations issued by the Department of the Treasury. The administrator may require you to provide evidence to document the event that requires the change of election.

**I CERTIFY THAT I HAVE INCURRED THE FOLLOWING CHANGE OF STATUS:**

**Change in Marital Status**

Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment

**Change in Number of Tax Dependents**

Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent

**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, decrees, or orders including the imposition of a Qualified Medical Child Support Order

**Change in Employment Status that Changes Eligibility Status**

Change of employment status, such as termination or commencement of employment by the employee, spouse, or Dependent

Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse, or dependent, including a switch between part-time and full-time (or vice-versa), a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.

Change in eligibility due to change in residency of the employee, spouse, or dependent

Special requirements relating to the Family and Medical Leave Act (FMLA) for the employee

Gain or loss of Medicaid or Medicare entitlement

**Change in Cost or Coverage (does NOT apply to Medical Reimbursement Accounts)**

- Significant cost increase in you or your dependent’s coverage
- Significant curtailment of you or your dependent’s coverage
- Addition or elimination of benefit package option under your or your dependent’s employer’s plan
- Change in coverage or open enrollment of spouse or dependent under another employer’s plan provided that the employee, spouse, or dependent elects coverage under the dependent’s plan
- Dependent Care provider is replaced by another
- Entitlement to COBRA (relates only to Core Medical Plans)
- HIPAA Special Enrollment Rights (relates only to Core Medical Plans)

**PLEASE CHANGE MY ELECTION(S) AS FOLLOWS:**

**Core Medical Plans (ex. Health Insurance)**

Change my insurance premiums to \$\_\_\_\_\_ per pay period effective with the \_\_\_\_\_ payroll.

**Medical Reimbursement Account**

Change my **ANNUAL** election for my Medical Reimbursement Account from \$\_\_\_\_\_ to \$\_\_\_\_\_. My new per pay deduction will be \$\_\_\_\_\_ effective with the \_\_\_\_\_ payroll.

**Dependent Care Reimbursement Account**

Change my **ANNUAL** election for my Dependent Care Reimbursement Account from \$\_\_\_\_\_ to \$\_\_\_\_\_. My new per pay deduction will be \$\_\_\_\_\_ effective with the \_\_\_\_\_ payroll.

**PLEASE NOTE: This form needs to be signed and dated within 30 days after the actual event date listed above.**

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

*Accepted and agreed to by:*

\_\_\_\_\_  
Employer Representative Signature Date