

# BENEFITHELP

Solutions

## FLEXIBLE SPENDING ACCOUNT STATUS CHANGE FORM

ID NUMBER	NAME: (Last)	(First)	(MI)	EMPLOYER

### TYPE OF CHANGE (Please Check All Appropriate Boxes and Complete Related Sections)

UNLESS OTHERWISE NOTED IN YOUR PLAN DOCUMENT, QUALIFIED STATUS CHANGES (QSC) MUST BE SUBMITTED WITHIN 30 DAYS OF THE EVENT. PLEASE DISCUSS WITH YOUR BENEFIT SPECIALIST TO DETERMINE IF YOUR EVENT IS A QSC.

- |                                                  |                                                                                                                                                        |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ADD FAMILY MEMBER(S)    | <input type="checkbox"/> OTHER (PLEASE DESCRIBE BELOW)                                                                                                 |
| <input type="checkbox"/> DELETE FAMILY MEMBER(S) | <input type="checkbox"/> JOB STATUS CHANGE (E.G., PART-TIME, FULL-TIME, LEAVE OF ABSENCE, RETURN FROM LEAVE, LAY-OFF, RETURN FROM LAY-OFF, TERMINATED) |
| <input type="checkbox"/> NAME CHANGE             |                                                                                                                                                        |
| <input type="checkbox"/> ADDRESS CHANGE          |                                                                                                                                                        |

_____	SELF
STREET, PO BOX (INCLUDE APT #)	SPOUSE
_____	WORK LOCATION
CITY, STATE, ZIP CODE	WORK PHONE NUMBER

**DESCRIPTION OF EVENT:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### QUALIFIED FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

I authorize my employer to place a portion of my salary, before taxes, in the Flexible Spending Account(s) listed below: (write in "0" if you do not wish to participate). *I understand that additional funds due to an increase in my election can only be used for charges incurred on or after the date of the change.*

INDICATE CHANGE TO ELECTION:

FROM \$ _____	TO \$ _____	HEALTHCARE REIMBURSEMENT ACCOUNT
\$ _____	\$ _____	DEPENDENT CARE REIMBURSEMENT ACCOUNT
\$ _____	\$ _____	EMPLOYEE PREMIUM CONTRIBUTION CHANGE
\$ _____	\$ _____	COMMUTER EXPENSE REIMBURSEMENT ACCOUNT

EFFECTIVE DATE OF CHANGE: \_\_\_\_\_

EMPLOYEE'S SIGNATURE	DATE
EMPLOYER APPROVAL	

PLEASE SUBMIT COMPLETED FORM TO YOUR HUMAN RESOURCES / BENEFITS DEPARTMENT