EMPLOYEE BENEFIT SYSTEMS
HELPING ADMINISTER YOUR SUCCESS

FSA, LFSA, DCA
Enrollment Change

Employer Name:			Date:
Employee Name:			SSN #
Street Address:			Email:
City:	State:	Zip:	Phone:

I certify I have incurred the following change in status and understand changes must be within 30 days of the event.

Change in Marital Status due to:

☐ Marriage ☐ Death of a Spouse ☐ Divorce ☐ Legal Separation

Change in Number of Dependents due to:

☐ Birth ☐ Death ☐ Adoption/Placement for Adoption

Change in Spouse or Dependent's Eligibility Under an Employer's Plan

☐ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirement of the plan

☐ Judgment, decree or order including the imposition of Qualified Medical Child Support Order

☐ Gain or loss of Medicaid or Medicare entitlement ☐ Entitlement to COBRA.

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, a strike or lockout, a change in worksite, commencement or return from an unpaid leave of absence or FMLA.

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

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

☐ Significant cost increase or curtailment of your 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 provider that the employee, spouse or dependent elects' coverage under the dependent's plan.

Change in Election due to Discrimination Testing

☐ Reduction in elections to comply with nondiscrimination rules.

Change in Election due to COVID 19

☐ Revoke or change election mid-year due to COVID 19

Administrative Error (attach an explanation)

☐ Employer such as, withholding employee funds, but enrollment form not sent

☐ Employee such as, elected dependent care in error, does not have children eligible for expense

Change my **Flex Spending Account** annual election from:	$	To: $
My new per pay period **Flex Spending Account** will be:	$	Payroll Effective Date:

Change my **Dependent Care Account** annual election from:	$	To: $
My new per pay period **Dependent Care Account** will be:	$	Payroll Effective Date:

Agreement

By signing and submitting this change form, I authorize all changes as indicated above and understand that any change must be permissible under Internal Revenue Service (IRS) regulations and as defined in the plan. I understand that this Status Change Form must be completed within 30 days of the change in status event, and the election change I have requested must be consistent with the change in status event. I certify that the above information is true and correct and agree to provide any necessary third-party documentation to verify the change in status event if requested. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination. I authorize any election amount(s) above to be deducted from payroll as indicated.

Employee Signature:	Date:
Employer Signature:	Date: