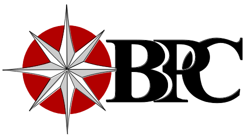

Status Change Form

Participant Name: ____ SS # XXX-XX-__________

Employer: ____

Participant Address:____

REASON FOR STATUS CHANGE

Check applicable box(es) to indicate the change in election event(s) that applies to your situation. Election changes generally cannot be retroactive and must be consistent with the Change in Election Event, as described at the end of this Form.

A. Change in Status (Health FSA, DCAP, and Health Plan Benefits)

Marital Status:

- ❑ Marriage
- ❑ Divorce or annulment
- ❑ Legal Separation
- ❑ Death of Spouse

Number of Tax Dependents:

- ❑ Birth
- ❑ Adoption or Placement for adoption
- ❑ Death of Dependent

Employment That Affects Eligibility:

- ❑ Termination of employment: ❑ You ❑ Spouse ❑ Dependent
- ❑ Commencement of employment: ❑ You ❑ Spouse ❑ Dependent
- ❑ Part-time to Full-time or Full-time to Part-Time: ❑ You ❑ Spouse ❑ Dependent
- ❑ Military Leave: ❑ You ❑ Spouse ❑ Dependent

Dependent's Eligibility Under an Employer's Plan:

- ❑ Lost eligibility (such as age, student status, marital status)
- ❑ Gained eligibility (such as age, student status, marital status)
- ❑ Gained eligibility due to change in "Adult Child" eligibility rules

Residence Affecting Eligibility: (Applies to Health Plan only)

- ❑ You
- ❑ Spouse or Dependent

B. Change in DCAP Cost/Provider: (applies to DCAP Benefits only)

- ❑ Significant increase or decrease in cost
- ❑ Change in dependent care provider(s)

C. Change in HRA Benefit

- ❑ Please describe: ____

D. Change in HSA Benefit (Applies to HSA Benefits only, may be done prospectively for any reason)

- ❑ Effective Date: ____

E. Other Event (See your Summary Plan Description for the list of other events that permit a change in election)

CHANGES IN DEDUCTIONS

FSA or HSA Medical Expenses	DCAP Dependent Care Expenses	HRA Election
Prior Deduction: $	Prior Deduction: $	Previous:
New Deduction: $	New Deduction: $	Change to:
Starting pay period date:	Starting pay period date:	
No. of pay periods remaining:	No. of pay periods remaining:	(Must be same as Health Ins Coverage)

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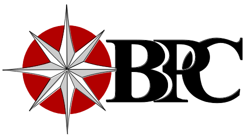

Status Change Form

DEPENDENT INFORMATION

Name	SS#	DOB	Relationship

STATUS CHANGE EFFECTIVE DATES (Check Applicable Boxes)

- ❑ **Change in Election**
  Effective ______________________[1] I hereby make a change to my existing election under my employer's Section 125 Plan (Health FSA, DCAP, Health Plans and HSA Components) and/or HRA Plan.
- ❑ **Revocation of Existing Election**
  Effective ______________________[1] I wish to **REVOKE** my existing election under my employer's Section 125 Plan (Health FSA, DCAP, Health Plans and HSA Components) and/or HRA Plan.

  Type of coverage being revoked (my prior election for all other types of coverage remains in effect):
  - ❑ Health FSA Benefits
  - ❑ DCAP Benefits
  - ❑ HRA Benefits
  - ❑ HSA Benefits

  Employer's Group Health Plans
  - ❑ For Myself
  - ❑ For Spouse
  - ❑ For Dependent(s)
- ❑ **New Election**
  Effective ______________________[1] I hereby make a new election as specified on the **attached** Enrollment Form for the appropriate Plan(s).

Please read carefully: I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with the Plan, and the Administrator has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or has become entitled to Medicare/Medicaid, or (b) a judgment, decree, or order requires an individual other than myself to provide accident or health coverage for my child, I certify that such new, improved, or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person.

If my change in election is denied, I understand that I will have to appeal the decision within the timeframe specified in the Summary Plan Description for the Plan.

If approved I hereby elect the change(s) noted above or by new election on the attached Enrollment Form and attest that the change is made on account of and is consistent with the change in election event.

(Required) **PARTICIPANT SIGNATURE:**	**DATE** **SUBMITTED:**

Accepted and agreed to:

EMPLOYER'S SIGNATURE:	**DATE** **APPROVED:**

Please complete and return this form to Benefit Planning Consultants

[1] In no event may the revocation/new election be effective prior to the first day of the pay period beginning after this Form is completed and returned to the Administrator, unless a new Dependent is being added to medical coverage pursuant to HIPAA Special Enrollment rights, in which case the new election may be consistent with the new medical insurance election, as applicable.