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CHANGE IN STATUS

Employer's Name:_____
Name:_____ **SS#:**_____

*Check the appropriate line to indicate a change in Family Status. One or more of the changes listed below qualifies you to change your Reimbursement Accounts and your Benefit Plan Elections. Changes must be submitted within **thirty (30) days** after the event and will become effective on the first payroll date after approval by the Plan Administrator. The election change that you make must relate directly to the change in status which occurred.

- ***CHANGE IN LEGAL MARITAL STATUS:***

☐ Marriage ☐ Divorce ☐ Legal Separation

- ***CHANGE IN NUMBER OF DEPENDENTS:***

☐ Birth or Adoption of a child ☐ Death of a Spouse or Dependent ☐ Court Order

- ***TERMINATION OR COMMENCEMENT OF EMPLOYMENT BY:***

☐ Employee ☐ Spouse ☐ Dependent

- ***CHANGE IN WORK SCHEDULE OR UNPAID LEAVE OF ABSENCE (must affect eligibility for benefits):***

☐ Employee ☐ Spouse ☐ Dependent

Explain:_____

- ***DEPENDENT SATISFIES OR CEASES TO SATISFY DEPENDENT ELIGIBILITY REQUIREMENTS:***

Explain:_____

- ***CHANGE IN RESIDENCE OR WORKSITE OF EMPLOYEE, SPOUSE OR DEPENDENT (Must result in change in eligibility):***

Explain:_____

- ***SIGNIFICANT CHANGE IN THE HEALTH COVERAGE OF THE EMPLOYEE OR SPOUSE ATTRIBUTABLE TO THE SPOUSE'S EMPLOYMENT:***

Explain:_____

- ***ENTITLEMENT TO MEDICARE OR MEDICAID:***

Explain:_____

- ***CHANGE IN DAYCARE PROVIDER OR IN THE COST OF DEPENDENT DAYCARE:***

Explain:_____

Please attach new Election Form

Signature:_____ Date:_____

Effective Date of New Coverage:_____
Effective Payroll Date:_____