



**Diversified  
Administration, Inc.**  
Tax Savings For Employers & Employees

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# Employee Change In Status Form

## Participant Information

Employer Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## Reason for Change in Status

\*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 Work Site 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: \_\_\_\_\_

## Employee Signature

Please send this completed form, along with a new election form, to [claims@div125.com](mailto:claims@div125.com)

Effective Date of New Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_    Effective Payroll Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Signature: \_\_\_\_\_