Diversified
Administration, Inc.
Tax Savings For Employers & Employees

3 Ways To Submit Your Claim Form and Receipts
E-mail: **Claims@Div125.com**
Fax 954-983-9695 or 954-983-0574
6600 Taft Street Suite 304, Hollywood, FL 33024

Reset the Form

Submit via E-Mail

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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.

☐ **Open Enrollment on MarketPlace Exchange (medical insurance coverage only).**
◯ Employee ◯ Spouse ◯ Dependent

☐ **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

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

Employee Signature: _____

Secure Upload

Submit via E-Mail