TERMINATION/STATUS CHANGE FORM

Member Information

Employer Name

Member Name

Social Security Number

Address

City

State

Zip

Phone

Birth Date (mm/dd/yyyy)

Hire Date (mm/dd/yyyy)

Termination of Employment

Date of Termination

Date Benefits End

Date of Final Pre-Tax Payroll Deduction

Payroll Frequency (check one): ☐ Monthly (12) ☐ Semi-Monthly (24) ☐ Bi-Weekly (26) ☐ Weekly (52)

Qualifying Event (QE) Information

Please choose the qualifying event that applies to the request for an election change. In accordance with the IRS Consistency Rule, changes to a cafeteria plan election due to a change in status must be consistent with the effect the change in status has on eligibility under the plan.

CHANGE IN NUMBER OF DEPENDENTS

☐ Increase in number of dependents due to birth, adoption or marriage

☐ Decrease in number of dependents due to death, divorce or loss of eligibility

DEPENDENT CARE CHANGES

☐ Change in daycare provider

☐ Change in cost of daycare

☐ Judgment, decree or order requiring change in coverage

EMPLOYMENT STATUS

☐ Loss of eligibility due to a change in employee, spouse or dependent employment status

☐ Gain of eligibility due to a change in employee, spouse or dependent employment status

OTHER

☐ Entitlement to or loss of Medicare or Medicaid coverage

☐ Special requirements relating to Family and Medical Leave Act (FMLA)

☐ COBRA election under employer's plan

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Election Change Information

Flexible Spending Account (FSA) Date of Qualifying Event (mm/dd/yyyy): _____

Date of first payroll deduction (mm/dd/yyyy)	1		The first payroll the change in election will affect
Previous annual election		$	
New annual election	2	$	The new annual election cannot be lower than the contributions to date, the total claims paid or greater than the employer designated maximum
Contributions to date	3	$	Enter the total contributions prior to the date placed in box 1
Remaining contributions	4	$	Subtract box 3 from box 2. This will total the contributions for the rest of the Plan Year
Number of remaining pay periods	5		The number of pay periods from box 1 through the end of the Plan Year
New per pay period deduction amount	=	$	Divide box 4 by box 5 to calculate the new amount to be deducted each pay period

Dependent Care (DC FSA) Date of Qualifying Event (mm/dd/yyyy): _____

Date of first payroll deduction (mm/dd/yyyy)	1		The first payroll the change in election will affect
Previous annual election		$	
New annual election	2	$	The new annual election cannot be lower than the contributions to date, the total claims paid or greater than the employer designated maximum
Contributions to date	3	$	Enter the total contributions prior to the date placed in box 1
Remaining contributions	4	$	Subtract box 3 from box 2. This will total the contributions for the rest of the Plan Year
Number of remaining pay periods	5		The number of pay periods from box 1 through the end of the Plan Year
New per pay period deduction amount	=	$	Divide box 4 by box 5 to calculate the new amount to be deducted each pay period

Signature

I understand that this Termination/Status Change Form must be submitted within a reasonable amount of time as deemed by the IRS and my employer. Further, I understand the election change I have requested must be consistent with the change in status event and the effective date of the election change may not be prior to the qualifying event date. I certify that the above information is accurate.

_____ _____
Employer Signature   Date

_____ _____
Member Signature   Date