



FSA/HRA/TMA Plan Change Form

- Change in Address
- Change in Family Status/Election

Company Name: _____

Employee Name: _____ SS# 900 _____

Address: _____

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in family status. I understand the change in my benefit election must be necessitated by and consistent with the change in family status and the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify I have incurred the following change in family status:

- Marriage**
Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment.
- Change in Number of Tax Dependents**
Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent.
- Change in Spouse or Dependent's Eligibility Under an Employer's Plan**
 - Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.
 - Judgment, decree or order including the imposition of a Qualified Medical Child Support Order.
 - Gain or loss of Medicaid or Medicare entitlement.
 - Entitlement to COBRA.
 - Special requirement relating to the Family and Medical Leave Act (FMLA).
- Change in Employment Status that Changes Eligibility Status**
 - Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.
 - Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.
 - Change in eligibility due to change in residency of the employee, spouse or dependent.
- Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only).**
 - Significant cost increase in your or your dependent's coverage.
 - Significant curtailment of your or your dependent's coverage.
 - Addition or elimination of benefit package option under your or your dependent's employer's plan.
 - Change in coverage or open enrollment of spouse or dependent under other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.
 - Dependent care provider is replaced by another.

Account being changed: Insurance Premium Dependent Care
 Medical Reimbursement Transportation Management Account

* Change amount to \$_____ per paycheck, effective on the _____ payroll. *

* Change amount to \$_____ per year election, effective on the _____ payroll. *

Employee's Signature: _____ Effective Date: _____

Accepted and agreed to by: _____ Date: _____
(Company Administrator signature is required)

Received by BeneFLEX HR Resources, Inc.: _____ Date: _____

FAX or MAIL
BeneFLEX HR Resources Inc.
314-909-6983 (fax)

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St. Louis, MO 63127
800-631-3539 (ph)