



CHANGE FORM
EMPLOYEE NAME, ADDRESS, STATUS
OR ELECTION AMOUNT CHANGE

Employer Name: _____

Plan Year (MM/YY): _____ through (MM/YY) _____

Employee # or SSN: _____ Employee Name on File: _____

Check Reason for Change:

Name Change (Provide New Name): _____

Address Change (Provide New Address): _____

Termination of Employment: Effective Date of Termination : _____

Date of Last Payroll Withholding for FSA, HRA or HSA : _____

Election Amount Change – Indicate Account Affected & Attach New Enrollment Form:

Healthcare Dependent Care Parking Transit HSA

New Election Effective on this Payroll Date : _____

New Payroll Withholding Amount Per Account : _____

Indicate *Family Status Change* (new payroll election date must be after the family status change date)

I certify that I have or will have incurred the following change in status:

- Marriage
- Divorce, Legal Separation or Annulment
- Birth, adoption or placement for adoption of a child
- Death of my spouse and/or dependent
- Termination or commencement of employment by my spouse or dependent
- Switch from part-time to full-time employment (or vice versa) for me, my spouse or a dependent OR a reduction/increase in hours, a strike or lockout
- Unpaid leave of absence for me, my spouse or dependent
- Significant change in health coverage due to spouse's employment
- Change in the residence or worksite of me, my spouse or dependent
- Dependent satisfies or ceases to satisfy the requirements of health coverage
- Other: _____

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

You may be required to provide evidence to document the event which requires the change of election. **This form must be sent through your employer so changes are made to your employee payroll record.**

Employee Signature : _____ Date: _____

Employer's Authorized Signature : _____ Date: _____