Flexible Spending Plan Change in Benefit Election

Employer: ______________________________

Employee Name: ______________________________

Soc. Sec. Number: ________ - ________ - ________

Address: ______________________________

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Please change my election for the remainder of this plan year as indicated below.

	Plan Benefit Per Check		Annual Plan Benefit	
	Change from	To	Change from	To
Medical Reimbursement	________	________	________	________
Dependent Care	________	________	________	________

Reason for Change (circle): **Date of Event** ______________________

1) Marital Status Change	Marriage	Divorce	Death	Annulment	Legal Separation
2) Number of Dependents	Birth	Adoption	Death	Marriage (of dependent)	
	Age	Student status	Military	Child turned 13 (Dependent Care only)	
	Other	______________________			

3) Change in Employment Status ______________________

(Explanation)

4) Change Dependent Care Provider ______________________

(From → To)

5) Judgment, Decree, or Court Order

6) FMLA Begin / End (circle one)

7) COBRA event ______________________

(Describe)

Payroll Issue Date of Change: ____________

Explanation if required: ______________________

______________________________ ____________

Employee Signature Date

End of Employment on ____________ ______________________

2000/11 Human Resources Signature