



MedBen Group #: _____

HEALTH and DEPENDENT CARE CHANGE REQUEST FORM

Name: _____ SS#: _____

Address: _____

PART 1: ELECTION / ADDRESS CHANGE REQUESTED (check applicable boxes)

Address Change: _____

Effective Date of New Address: _____

- Revocation of an Existing Election:**
 Effective**: _____, I wish to **REVOKE** my existing election under my Employer's Flexible Spending Plan.
- Type of Coverage being revoked: (my prior election for all other types of coverage remains in effect)
- Health Flexible Spending Plan
 Dependent Care Assistant Plan

- New Election:**
 Effective**: _____, I hereby make a **NEW** election as specified on the attached Flexible Spending Plan Enrollment Form.

PART II: THE CHANGE(S) IN ELECTION EVENT(S) ON WHICH MY REQUEST IS BASED IS/ARE:

CHECK ALL APPLICABLE BOXES to indicate the Change in Election Event(s) that apply to your situation. Election changes generally cannot be retroactive, and must be consistent with the Change in Election Event as described in Part III.

- FMLA Leave:** (Insurance Premiums and Health FSA premiums to be paid as follows while on leave)
- After-Tax, by sending in payments
 Pre-Tax, by prepayment
 Other (as agreed with Administrator) _____
- Changes in Status:** (applies to Flexible Benefit Plan(s) listed above; for Health FSA benefits, may seek to increase or cancel, but not reduce coverage)
- Change in Marital Status**
- Marriage
 Divorce or Annulment
 Legal Separation
 Death of Spouse
- Change in Number of Tax Dependents**
- Birth of a child
 Adoption or placement for adoption
 Death of a dependent
- Change in Employment Status That Affects Eligibility** (please check affected person)
- | | | | |
|--|------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> Termination of employment | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Commencement of employment | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Part-time to full-time | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Full-time to part-time | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Strike or lock-out | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Return from unpaid leave of absence | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Change in worksite | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Other (salary to hourly, etc) | <input type="checkbox"/> You | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |

Provide Details: _____

- Change in Dependent's Eligibility Under an Employer's Plan**
- Lost eligibility (such as age, student status, marital status)
 Gained eligibility (such as age, student status, marital status)

