Change in Status Notification Form
Flexible Benefits

Employer Name: _____

Employee Name: _____

Employee ID: _____

Change Effective Date: _____

As a participant in the above Employer's Flexible Benefits Program, I am entitled to change or revoke my prior benefit 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.

I certify that I have experienced the following change in status:

- ☐ Marriage
- ☐ 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
- ☐ Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse, or dependent or reduction or increase in hours, strike or lockout
- ☐ I, my spouse or dependent have taken an unpaid leave of absence
- ☐ A change in the residence or worksite of myself, my spouse or dependent
- ☐ My dependent satisfies or ceases to satisfy the requirements for coverage
- ☐ Other (please describe): _____

Due to this change, please process the following as of the above effective date:

- ☐ Terminate my participation in the _____ Plan (e.g. Health Care, Dependent Care FSA, HRA, TIP, etc.)

- ☐ Change my annual election in the _____ Plan (e.g. Health Care, Dependent Care FSA, HRA, TIP, etc.) FROM _____ to _____.

- ☐ Other (please describe): _____.

By signature below, I acknowledge the requested change is true and valid.

_____ Date_____
Employee's signature

_____ Date_____
Plan Administrator

Please return form to:
HealthSmart Benefit Solutions
P.O. Box 3262, Charleston, WV 25301
Fax: 877.587.4434 Email: nngg_cs@healthsmart.com
Phone: 800.503.9098