EBMS
Employee Benefit Management Services, Inc.

FLEXIBLE SPENDING ACCOUNT (FSA) STATUS CHANGE FORM

Employer Name: _____ Client ID #: _____

Employee Name: _____ Social Sec. #: _____

Employee Address: _____

City/State/Zip code: _____

Type of Change (Note: Change in election must be consistent with the status change event.)

- ☐ Change in employee's legal marital status including marriage, divorce, spouse's death, legal separation, and annulment.
- ☐ Change in the number of tax dependents including birth, adoption, placement for adoption, or death.
- ☐ Change in employment status of employee, spouse or dependent that affects eligibility including reduction or increase in hours, termination or commencement of employment.
- ☐ Change in dependent care provider or change in provider's cost (change in cost does not apply if provider is a relative of the employee.)
- ☐ Dependent satisfies (or ceases to satisfy) dependent eligibility requirements including attainment of age, student status, etc.
- ☐ Other. Please explain: _____

Effective Date (Note: Changes in coverage and funding cannot be retroactive except for birth, adoption, or placement for adoption. Effective date is determined by the benefits office in accordance with IRS Regulations governing Section 125 plans.)

Date of Qualifying Status Event _____ Effective Date of Change _____

Health Care Flexible Spending Account

Old Annual Election $ _____ New Annual Election $ _____ (A)*

*New annual election amount cannot be less than the total reimbursement paid of payable to you YTD from your Account

YTD Deduction Amount (as of effective date of change) $ _____ (B)
Amount to be deducted over remainder of plan year (A minus B) $ _____ (C)
Number of payperiods remaining for plan year _____ (D)
New per payperiod deduction amount (C divided by D) $ _____

Dependent Care Flexible Spending Account

Old Annual Election $ _____ New Annual Election $ _____ (A)*
YTD Deduction Amount (as of effective date of change) $ _____ (B)
Amount to be deducted over remainder of plan year (A minus B) $ _____ (C)
Number of payperiods remaining for plan year _____ (D)
New per payperiod deduction amount (C divided by D) $ _____

Authorization

The information I have provided is true, correct and complete, and amends previously submitted information. I authorize my employer to make any payroll deductions or adjustments resulting from my request change.

_____ _____
Employee Signature Date

_____ _____
Human Resource Representative Signature Date

Status Change Form must be submitted within 30 days of the changing event to your Human Resource Representative.