

**FAMILY STATUS/LIFE EVENT CHANGE FORM
FLEXIBLE SPENDING ANNUAL ADJUSTMENT**

Name: _____

Social Security #: _____

Note: A salary change does not qualify as a FAMILY STATUS CHANGE. This form must be submitted to your plan administrator within 30 days from the date of the family status change.

CHECK ONE OF THE FOLLOWING:

- _____ Marriage
- _____ Divorce/Legal Separation/Annulment
- _____ Death (Spouse/Child)
- _____ Birth/Adoption of Child
- _____ Commencement or termination of adoption proceedings
- _____ Entitlement to Medicare or Medicaid (does not apply to Dependent Care Acct)
- _____ Termination of Spouse's employment; Strike or Lockout
- _____ Commencement of Spouse's employment
- _____ Employee or spouse changing from part-time to full-time employment or full-time to part-time employment
- _____ Employee or spouse taking an unpaid leave of absence
- _____ Any significant change in the health coverage of the employee or spouse due to changes in spouse's employment
- _____ Any legal judgments, decrees or orders
- _____ Any changes to your Dependent Care service provider or in the cost of care (applies only to Dependent Care Acct)

Please indicate date of family status change/life event: _____

NOTE: Each request for adjustment will be reviewed to be certain the requested action is consistent with the life event/family status change per IRS regulations.

HEALTH CARE REIMBURSEMENT ACCOUNT

- Opt. A Cease Contributions
- Opt. B Increase annual election amount to \$ _____
- Opt. C Decrease annual election amount to \$ _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT

- Opt. A Cease Contributions
- Opt. B Increase annual election amount to \$ _____
- Opt. C Decrease annual election amount to \$ _____

Note: The Payroll Department will make the adjustments to your paycheck deductions based on your indicated adjusted annual election amount.

EMPLOYEE'S SIGNATURE: _____ DATE: _____