

**FLEXIBLE BENEFIT PLAN  
CHANGE IN STATUS FORM**

**EMPLOYER** \_\_\_\_\_  
(Please print above)

Employee's name \_\_\_\_\_ SS# \_\_\_\_\_

As of (date) \_\_\_\_\_ I have had a change in my family status due to:

- \_\_\_\_\_ Marriage
- \_\_\_\_\_ Divorce, Legal Separation or Annulment
- \_\_\_\_\_ Birth, adoption or placement for adoption of a child
- \_\_\_\_\_ Death of my spouse/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
- \_\_\_\_\_ My dependent satisfies or ceases to satisfy the requirements for coverage
- \_\_\_\_\_ Other: \_\_\_\_\_

As a result of this change, I request a change in my election per pay period.

	<u>PREVIOUS</u>	<u>NEW</u>
HEALTH CARE EXPENSES	_____	_____
DEPENDENT CARE EXPENSES	_____	_____
PRIVATE INSURANCE EXPENSES	_____	_____

This change is to become effective with the pay period ending on \_\_\_\_\_

\_\_\_\_\_  
Employee's Signature Date

Approval: By \_\_\_\_\_ Title \_\_\_\_\_  
                  Authorized Person

<b>Mail This Claim Form To:</b> Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	<b>Fax Claim Form To:</b> Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155
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**Please DO NOT mail your form if you fax it. Thank you.**

● Documentation must be attached verifying change in status.