

Premium Only

Plan or (POP)

Change in Family Status Form

(Fill out only to request a Change in participation during the year)

Employer: Benton County

Full Name (Please Print): _____

Check the appropriate box to indicate a Change in Family Status. One or more of the events listed below qualifies you to change your Redirected Amounts or your participation in the FSA during the Plan Year. Changes cannot be retroactive and must be consistent with the events indicated.

Change in Marital Status Marriage
 Date of Status Change: _____ Divorce
 Legal Separation

Change in Dependent Status Birth
 Date of Status Change: _____ Adoption
 Death
 Loss of Dependent

Change in Work Status

	You	Your Spouse	
Termination of Employment	<input type="checkbox"/>	<input type="checkbox"/>	
Commencement of Employment	<input type="checkbox"/>	<input type="checkbox"/>	
Part-time to Full-time	<input type="checkbox"/>	<input type="checkbox"/>	
Full-time to Part-time	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

Date of Status Change: _____

Other Change in Family Status (Explain in detail.) Date of Status Change: _____
 Documentation verifying all changes listed above may be required. Fill out appropriate redirection form(s) to indicate the change(s) you wish to make. Changes you may make include, but are not limited to, changes for health, accidental death and dismemberment, life insurance or with-drawing from or adding to participation.

I understand that I may be required to provide the appropriate documentation for any of the changes in family status that I have checked above. The family status and participation changes will be reviewed.

I HEREBY ELECT THE PARTICIPATION CHANGE(S) NOTED ON THE REDIRECTION FORM ATTACHED AND ATTEST THAT THE CHANGE IS CAUSED BY AND CONSISTENT WITH THE CHANGE IN FAMILY STATUS.

Employee: _____

 Signature

Accepted and agree to:
 By: _____
 Plan Administrator/Employer

Date: _____

Date: _____