



P.O. Box 43653 Louisville, KY 40253-0653 (502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 www.bmsllc.net

Change in Status/Termination Form

As a participant in the Section 125 Cafeteria Plan, I am entitled to revoke my prior benefits election and enter a new election in the event of certain IRS change in status rules and regulations. I understand that the change in my benefits election must be due to and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

Employer _____ Employee Name _____

Social Security # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Effective Date of Change _____ If Terminating, Date of Last Deduction _____

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

Change in Marital Status

_____ Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment.

Change in Number of Tax Dependents

_____ Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent.

Changes in Spouse or Dependent's Eligibility Under an Employer's Plan

_____ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.

_____ Judgment, decree or order including the imposition of a Qualified Medical Child Support Order.

_____ Gain or loss of Medicaid or Medicare entitlement.

_____ Entitlement to COBRA.

_____ Special requirements relating to the Family and Medical Leave Act (FMLA).

Change in Employment Status that Changes Eligibility Status

_____ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.

_____ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.

_____ Change in eligibility due to change in residency of the employee, spouse or dependent.

Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only)

_____ Significant cost increase in your or your dependent's coverage.

_____ Significant curtailment of your or your dependent's coverage.

_____ Addition or elimination of benefit package option under your or your dependent's employer's plan.

_____ Change in coverage or open enrollment of spouse or dependent under another employer's plan provided that the employee, spouse or dependent elects' coverage under the dependent's plan.

_____ Dependent care provider is replaced by another.

Please change my election(s) as follows:

Health FSA Account

Change my annual election for my **Health FSA** from: \$ _____ to \$ _____.

My new per pay period election will be \$ _____ effective with the _____ payroll.

Dependent Care FSA Account

Change my annual election for my **Dependent Care FSA Account** from \$ _____ to \$ _____.

My new per pay period election will be \$ _____ effective with the _____ payroll.

Comments: _____

Employee Signature: _____ Date: _____

Accepted and agreed to by Employer Representative:

Company Representative Signature: _____ Date: _____