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

Change in Family Status Form/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 ______________________________________

Last Four Digits 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 or 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 or curtailment in you 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 for the above reasons:

Health FSA Account

Change my annual election for my **Health FSA Account** 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.

Employee Signature:____________________________________ Date:____________________________________

--MUST BE SUBMITTED TO BMS LLC VIA YOUR EMPLOYER FOR PROPER PROCESSING--