Flexible Spending Plan
Change of Status Form

Participant Must Apply Within 30 Days of the Qualifying Event for a Status Change.

PLEASE PROVIDE THE FOLLOWING INFORMATION		
Employee Name	Worksite Employer	9 Dig. Social Security Number

Today's Date: _____/_____/_____

I hereby apply for a change in my Flexible Spending Plan Deduction based upon the following event, which occurred on _____/_____/_____;

Choose One: The change in status must be in accordance with the account you are changing.

Marital Status Change:

____ Marriage: New Last Name: _____
____ New Spouse Name: _____
____ Divorce
____ Death
____ Legal Separation
____ Annulment

Change of Dependent Status:

____ Birth: Name of dependent: _____
____ New Dependent: Name: _____
____ Adoption: Name: _____
____ No Longer Dependent: Name: _____
____ Death: Name: _____

Participant Employment Change:

____ Unpaid Leave of Absence
____ Return from Unpaid Leave of Absence
____ Part-time to full-time or reverse

Spousal Employment Status Change:

____ Spouse Commencement of Employment
____ Spouse part-time to full-time or reverse
____ Spouse Termination of Employment

____ **Day Care Only**: Change of Day Care Fees (provider may not be a relative)

NEW BENEFIT ELECTION

NEW HEALTH CARE EXPENSES: $_____ **TOTAL 2016 ELECTION**
Maximum Annual Election is $2550.00.

NEW DAY CARE EXPENSES: $_____ **TOTAL 2016 ELECTION**
Maximum Annual Allowable Election is $5000.00 or $2500.00 if married and filing taxes separately.

EMPLOYEE Signature	**Date**

Return this form to A PLUS BENEFITS INC.: FAX: (801) 723-3006, EMAIL: fsa@aplusbenefits.com
OR MAIL: to P.O. BOX 308 AMERICAN FORK, UT 84003