Clear Form

Name or address change ☐

Flexible Spending Plan Change in Benefit Election

Employer: _____

Employee Name: _____

Soc. Sec. Number: _____ - _____ - _____

Address: _____

_____

Please change my election for the remainder of this plan year as indicated below.

	Plan Benefit Per Check		Annual Plan Benefit	
	Change from	To	Change from	To
Medical Reimbursement				
Dependent Care				

Reason for Change (select): **Date of Event** _____

1) Marital Status Change ☐Marriage ☐Divorce ☐Death ☐Annulment ☐Legal Separation

2) Number of Dependents ☐Birth ☐ Adoption ☐Death ☐Marriage (of dependent)
☐Age ☐Student status ☐Military ☐Child turned 13 (Dependent Care only)
☐Other _____

3) Change in Employment Status _____
(Explanation)

4) Change Dependent Care Provider _____
(From → To)

5) Judgment, Decree, or Court Order _____
(Describe)

6) FMLA ☐Begin ☐ End (select one)

7) COBRA event _____
(Describe)

Date of Change on PayCheck: _____

Explanation if required: _____

_____ _____
Employee Signature Date

ASCHG-FLEX
2007/10