CHANGE IN STATUS

PLEASE SELECT YOUR REASON FOR CHANGE

☐ **Change in Address** ☐ **Change in Status/Election**

Name:		Effective Date:	
Social Security #:		Home Address:	
Company:			

Complete this form to request a mid-year election change. The change must be must be made within 30 days of the qualifying event and be consistent with the qualifying election change event you indicate below. A qualifying event is not required for election changes to the Transit Management Account or Health Savings Account.

I CERTIFY I HAVE INCURRED THE FOLLOWING CHANGE IN STATUS:

☐ **Marriage**

- 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.

Change 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 requirement 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.**

☐ **HIPAA Special Enrollment Right**

Change in Cost or Coverage*

☐ Significant cost change 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 other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.*

☐ Change in Dependent Care Provider*

☐ Healthcare.gov Marketplace event: reduction in hours (less than 30 hours)**

☐ Healthcare.gov Marketplace enrollment during open or special enrollment period.**

* Applicable to insurance premium and dependent care assistance account elections only
** Applicable to Health Insurance Premiums elections only.

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ACCOUNT BEING CHANGED:

	Current Payroll Deduction Amount	New Payroll Deduction Amount
☐ Healthcare Flex Spending Account	$	$
☐ Dependent Day Care Flex Spending Account	$	$
☐ Limited Purpose Healthcare Flex Spending Account	$	$
☐ Transit Flex Spending Account	$	$
☐ Parking Flex Spending Account	$	$
☐ Health Savings Account (HSA)	$	$
☐ Insurance Premium	$	$

Employee Signature: _____ Date: _____

Accepted and agreed to by: _____ Date: _____

(Company Administrator signature is required)

Received by Paylocity: _____ Date: _____

Return completed form to Paylocity:
Secure Email: batinfo@paylocity.com | Fax: 314-909-6983 | Mail: Benefit Administration Technologies Inc. PO Box 7410394 Chicago, IL 60674-0397

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