

FLEXIBLE BENEFITS PLAN
CHANGE IN BENEFIT ELECTION FORM

(Must be completed within 30 days of the change in status)

General Information

School Name _____

Employee Name _____ Soc.Sec.No. _____

Benefit Election Changes

Please change the amount of my election **PER PAY PERIOD** as follows:

	FROM	TO
<input type="checkbox"/> Premium Account	\$ _____	\$ _____
<input type="checkbox"/> Health Flexible Spending Account (FSA)	\$ _____	\$ _____*
<input type="checkbox"/> Dependent Care Flexible Spending Account (FSA)	\$ _____	\$ _____

Date of first payroll deduction in which change applies: ____/____/____

***NEW ANNUAL HEALTH FSA MAXIMUM \$ _____ (to be verified by employer)**

The changes requested above are **on account of and correspond with** (see reverse side*) the change in status checked below and occurring on the date shown. (Election changes must occur within thirty (30) days of the event.)

PLEASE NOTE: Changes are "effective" on the date of the event or the date the employee signs this change in benefit election form, whichever is LATER. Retroactive changes are not permissible.

- Change in Legal Marital Status (**circle one**): Marriage; divorce; death of spouse; legal separation or annulment occurring on ____/____/____.
- Change in Number of Tax Dependents (**circle one**): Birth; adoption; placement for adoption; or death of a dependent occurring on ____/____/____.
- Change in Employment Status of Employee, Employee's Spouse or Dependent (**circle one**): Termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; or any other change in employment status which affects employee's eligibility for benefits occurring on ____/____/____.
- Change in Dependent Eligibility (**circle one**): Dependent satisfies or ceases to satisfy the requirements for coverage due to: attainment of specified age or similar circumstance occurring on ____/____/____.
- Change in Residence (**circle one**): (Employee, spouse or dependent moving in or out of HMO territory) occurring on ____/____/____.
- Change of Dependent Care Provider occurring on ____/____/____. (Please note: a new Dependent Care Certification Form will need to be completed by the participant.)
- Change in Hours of Required Dependent Care (e.g. disenrollment in school or enrollment in school) occurring on ____/____/____.
- Significant change in the Health Coverage of the Employee or Spouse Attributable to the Spouse's Employment occurring on ____/____/____. (Please attach explanation.)
- HIPAA Special Enrollment Event (Pre-tax Premiums only) occurring on ____/____/____. (Please attach explanation.)

- Judgment, Decree or Order (resulting from a divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order) occurring on ____/____/____. *(Please attach explanation.)*
- Entitlement to Medicare or Medicaid occurring on ____/____/____.
- Open enrollment of spouse's employer's Plan occurring on ____/____/____.

Original benefit elections will remain in effect for those accounts not affected by the above changes unless they are revoked because of a further change in status.

Employee Signature Date: _____

School Representative's Signature Date: _____

***Consistency Requirement.** Remember that all Participant election changes must be consistent with the change in status. For example, for the birth of a child, it would be consistent to increase the health care spending account election, not decrease. For more assistance on whether or not an election change would meet the consistency requirement, visit the following website and enter the change requested: www.changeofstatus.com. Call CSI or Arcadia Benefits Group for further assistance.

Please Return this Form to:

CSI Flexible Benefits Plan
3350 East Paris Avenue, SE
Grand Rapids, MI 49512
Email: sfeikema@CSOnline.org
Phone: (616) 284-3228 • Fax: (616) 301-2149 • Toll Free: (877) 274-8796, ext. 228