



CSI Flexible Benefits Plan
Employee Status Change Form

School Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Change in Employee Information

Name Change to: \_\_\_\_\_

Address: \_\_\_\_\_

Number/Street

City

State

Zip

Termination of Employment

Date of Termination: \_\_\_/\_\_\_/\_\_\_

Date of Last Payroll Deduction: \_\_\_/\_\_\_/\_\_\_

Reinstatement due to election of COBRA coverage for Health FSA

Amount of Health FSA Monthly Premium (annual election ÷ 12 = \$ \_\_\_\_\_)

Leave of Absence

Date of Leave: \_\_\_/\_\_\_/\_\_\_

Date of Anticipated Return: \_\_\_/\_\_\_/\_\_\_

Does leave qualify under FMLA? Yes No Date of Last Payroll Deduction: \_\_\_/\_\_\_/\_\_\_

If FMLA, is employee revoking coverage? Yes No (If yes, Arcadia will enter a termination date and claims incurred during the leave will not be eligible for reimbursement)

If continuing coverage, which payment options have been chosen? Pre-pay (pre-tax) Pay-as-you-go (after tax) Catch-up (pre-tax)

School Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail or Fax to:

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