

## Section 125 Flexible Benefit Plan Change of Status Request Form



If you have questions, contact your human resources department or call Chard, Snyder & Associates, Inc. at (513) 459-9997, toll free (800) 982-7715, or email at flex@chard-snyder.com.

### 1. Participant Information

Employer \_\_\_\_\_

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address \_\_\_\_\_ Check if New Address  Email Address (optional) \_\_\_\_\_

If your qualifying event was incurred by a spouse or eligible dependent, then please provide the following information:

Name _____	Relation to Employee _____	Date of Birth (if eligible dependent) _____
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### 2. Change of Status

**Please check the box next to the appropriate change of status and provide a brief explanation of the qualifying event. Check all categories that apply. You may be required to provide documentation supporting your qualifying event.**

- Change in Marital Status (marriage, divorce, death of spouse, legal separation or annulment)
- Change in Number of Dependents (birth, adoption, or death)
- Change in Employment and/or Eligibility of Self, Spouse or Dependent
- Change in Daycare Provider and/or Rates (dependent care reimbursement account only)
- Leave of absence in accordance with the Family Medical Leave Act  
Check one:  Pre-Pay Option     Catch-Up Option     Opt-Out Option     Pay As You Go
- Other Change

Explanation: \_\_\_\_\_

### 3. Change of Election



**Healthcare Reimbursement Account**  
This is for out-of-pocket medical /dental / vision expenses

New Payroll Deduction Amount  
\$ \_\_\_\_\_



**Dependent Care Reimbursement Account**  
This is for child and/or adult daycare expenses.

New Payroll Deduction Amount  
\$ \_\_\_\_\_



**Other Section 125 Plan Benefit (please specify):**  
\_\_\_\_\_

New Payroll Deduction Amount  
\$ \_\_\_\_\_

### 4. Certification

I hereby certify that the Information supplied on this form is true and accurate.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(For office use only)*

Approved  Denied

Effective Date \_\_\_\_\_

HR Representative Initials \_\_\_\_\_

*Please return this form to your human resource representative  
on or before the end of your change of status grace period.*