



# Flexible Spending Account Benefit Change In Status Request Form

Group Name: The City of Lake Forest Group Number: 010102

Employee Name: \_\_\_\_\_ IID# \_\_\_\_\_

**CHANGE IN FAMILY STATUS:** Effective Date of Change: \_\_\_\_\_

- Change In Legal Marital Status
- Change In the Number of Dependents
- Change In Dependent Eligibility
- Court Order Event
- Death of a Spouse or Child
- Medicare or Medicaid Entitlement
- Experienced a Significant Change in Medical Coverage for Self and/or Spouse Attributable to Change In Employment
- Residence Change that affects eligibility for coverage
- Change in Dependent Care Provider for reason of cause
- Child reached age 13 and is no longer a qualified individual for Dependent Care.

**CHANGE IN EMPLOYMENT STATUS:**

\_\_\_\_\_ **Termination of Employment** Termination Date: \_\_\_\_\_

- The employee has been notified of the claims submission timeframe from the date of termination to submit claims incurred prior to the date of termination.
- The employee has been notified their Flex Debit Card is active for 3 years from the date of issuance. Cards will be disabled at termination, however, should be saved in the event of rehire or a fee is assessed for new cards.
- The employee has been notified that COBRA must be elected to continue a Flex Account after their date of termination.

\_\_\_\_\_ **Leave of Absence (LOA)** Last day worked: \_\_\_\_\_

\_\_\_\_\_ **Return from Leave of Absence (LOA)** Return Date: \_\_\_\_\_

**DEDUCTION AMOUNT CHANGE:**

Changing Medical Deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ per pay period

Changing Dependent Care Deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ per pay period

\_\_\_\_\_  
(Signature of Employee)

\_\_\_\_\_  
(Date)

<b>Employer's use only</b>
Date of new deduction _____ or Date of last deduction _____
<b>Please fax this form to PBA, Inc. 630-286-4601.</b>