Professional Benefit Administrators, Inc.

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.

No Change in Status Required Through Dec 31, 2020 Due to the COVID Pandemic

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)

Employer's use only

Date of new deduction_____ or Date of last deduction _____

Please fax this form to PBA, Inc. 630-286-4601.