AMERICAN BENEFITS GROUP

FLEXIBLE SPENDING ACCOUNTS – QUALIFIED STATUS CHANGE FORM

For Plan Year Benefit Election Change

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Requested Effective Date:_____

I hereby change my benefit election and compensation reduction agreement under the Flexible Benefit Program with respect to the following individual plans:

Election(s) to Change*	New Annual Election
☐ Health Flexible Spending Account (FSA)	$
☐ Dependent Care Assistance Plan (DCAP)	$
Reason for Requested Change (see below):	

I hereby request to change my benefit election(s) as indicated above, due to a "Change in Status" Event (see list below). By signing this change form, I attest that the reason given for the requested change is valid. Any benefit election(s) and/or compensation reduction agreement already in place with my employer for which I have not requested to change shall remain in effect as is.

Employee's Signature: _____ Date: _____

* This revocation will not be effective unless it is made because of a change in status as defined in the Plan Document, nor will it be effective until the pay period following the completion and return of this form.

Qualified Reasons for Benefit Election Change(s)

A revocation and election change is considered qualified under the following circumstances:

- Significant change in cost of dependent care (i.e. change of provider)
- Change in status event (change in election must be consistent with change in status):
  - change in employee legal marital status
  - change in number of dependents
  - change in employment status
  - change in work schedule (Dependent Care change only)
  - dependent satisfies/ceases to satisfy plan requirements for unmarried dependents
- Judgement, decree, or court order
- Entitlement to Medicare or Medicaid

All requests for change or revocation of benefit elections will be subject to review by the Plan Administrator and any consultants he wishes to employ and no change shall be considered effected until accepted as qualified by the Plan Administrator.

Accepted and agreed to by the Plan Administrator by the power vested in him/her:

Benefits Administrator: _____ Date: _____

Fax Toll Free: 877-723-0147 or email to processing@amben.com

No Fax Machine? Mail to: American Benefits Group • P.O. Box 1209, Northampton, MA 01061-1209 • 800-499-3539