

Plan Year _____
Flexible Benefits
Plan Change Form



PO Box 587
 Pittsford, NY 14534
 Phone: 800.836.8100
 FAX: 585.248.2488

Employee Required Information (Please Print)

Employer:	Plan Year:											
Employee Name:	Confirm Last 4 of SSN (Current Employees): <table border="1"> <tr> <td>X</td><td>X</td><td>X</td><td>■</td><td>X</td><td>X</td><td>■</td><td></td><td></td><td></td><td></td> </tr> </table>	X	X	X	■	X	X	■				
X	X	X	■	X	X	■						
Email Address:	Phone Number:											

Employee Personal Data Change (Please Print)

Employee Name Change:
 (Former Name)

Select Eligible Change Event Below:

<input type="checkbox"/> Employee Termination	Event Date:
<input type="checkbox"/> Spouse Employment Change	Event Date: (PT or FT, Hours, Days of Week)
<input type="checkbox"/> Participant's Legal Marital Status	Event Date: Type of Change: (Divorce, Married, Separated, Other)
<input type="checkbox"/> Number of Tax Reported Dependents	Detail:
<input type="checkbox"/> Work Schedule	New Work Schedule: (PT or FT, Hours, Days of Week)
<input type="checkbox"/> Residence Update	New Address:
<input type="checkbox"/> Dependent Satisfies/Ceases to Satisfy Dependent Eligibility Requirements	Detail:
<input type="checkbox"/> Dependent Care Cost or Provider	Care Provider Name and Cost Change: (MUST Complete NEW DC Registration Statement):
<input type="checkbox"/> I no longer have Dependent Care services	Reason:
<input type="checkbox"/> COVID-19 (subject to plan approval)	

	New TOTAL Plan Year Election Amount (subject to plan approval)	Requested Payroll Date Change (subject to payroll processing)
Health Expense (Unreimbursed Medical, Dental, Vision, FSA, HE)	\$	
Dependent Care (DC)	\$	
Other: _____	\$	

Employee Authorization: _____ **Date:** _____

Received & Processed on: _____