Change in Status Election Form

Employee Information

Name: ____ SSN: ______ - ____ -_____

Home Address: ____

Campus: _______________________ Phone/Office Extension: ______________________

Designation of Status Change

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter a new election in the event of certain changes in family status. I understand that the change in my benefit election must be necessitated by and be consistent with the change in family status and that the change must be acceptable under the regulations issued by the Department of Treasury. I certify that I have incurred the following changes in family status:

- ☐ Marriage
- ☐ Divorce/Separation
- ☐ Death of a spouse and/or dependent
- ☐ Birth or adoption of child
- ☐ Termination/Commencement of employment by spouse
- ☐ My spouse/I have taken an unpaid leave of absence
- ☐ A significant change in family's health coverage due to spouse's employment
- ☐ Other (explain): ____

This change occurred on: ______________ Coverage change should take effect ______ (Month) 20 ___

Indicate Coverage(s) to be ADDED

	SSN	Last Name First MI	Sex	DOB	MED	DEN	VIS	LIFE	OTHER
EMP									
SP									
CH									
CH									
CH									
CH									

Indicate Coverage(s) to be TERMINATED

	SSN	Last Name First MI	Sex	DOB	MED	DEN	VIS	LIFE	OTHER
EMP									
SP									
CH									
CH									
CH									
CH									

Indicate Changes in Flexible Spending Account

______ Medical Expense Reimbursement Account $______/per pay period for a total of $__________/per year

______ Dependent Care Reimbursement Account $_______/per pay period for a total of $__________/per year

Retroactive Effective Date/Back Premiums

Please initial. ____ Yes, I authorize TISD to deduct additional money from my paycheck to make elected coverage effective the date of the qualifying event.

I hereby confirm the change in benefit elections selected above and certify that the documents I have provided are true and correct to the best of my knowledge.

Employee Signature: ____ Date: ________________________________

Date received by Benefits Office: ________________________