

Strategic Business Services Flexible Benefit Account Change of Status/Enrollment Adjustment Form

Remit To:
Strategic Business Services
425 Metro Place N.
Suite 140
Dublin, OH 43017
Fax: 614-889-6129
Email: fsa@maketherightmove.biz

Information provided is maintained for the administration of your benefits. If you have questions about your information or believe that information provided may be incorrect, please notify your benefits coordinator or plan administrator.

SECTION A: AGENCY AND EMPLOYEE INFORMATION

Employer Name:					
Employee Name:		SSN:			
Employee Address:			Apt/Suite:		
City:		State:		Zip:	
Email:			Phone:		

SECTION B: CHANGE OF STATUS REASON

Change of Status Description:				
Change of Status Date:		Change of Status Reason Code:		

You must complete a Change of Status Form for each qualifying life event. Please see page 2 for Reason Codes.

SECTION C: BENEFIT ELECTION CHANGES

<input type="checkbox"/> I WANT TO CHANGE AN EXISTING BENEFIT ELECTION	FROM	TO	
<input type="checkbox"/> Unreimbursed Medical Flexible Spending Account	Annual Election Amount	\$	\$
	Per-Pay-Period Election Amount	\$	\$
	Payroll Date when change will be made effective (MM/DD/YY)		
<input type="checkbox"/> Dependent Care Reimbursement Account	Annual Election Amount	\$	\$
	Per-Pay-Period Election Amount	\$	\$
	Payroll Date when change will be made effective (MM/DD/YY)		
<input type="checkbox"/> I WANT TO TERMINATE AN EXISTING BENEFIT ELECTION			
<input type="checkbox"/> Unreimbursed Medical Expense Account	Payroll date of last payroll deduction (MM/DD/YY)		
<input type="checkbox"/> Dependent Care Reimbursement Account	Payroll date of last payroll deduction (MM/DD/YY)		

SECTION D: AUTHORIZATION

By signing this form I certify that I or an eligible dependent has had a qualifying change in status, as defined by the Internal Revenue Service, which allows me to change my previous benefit election(s). I request that the indicated changes above are made to my benefit elections as a result.

Employee's Signature: _____ Date: _____

Accepted and Agreed by:

Employer Representative: _____ (Print Name) _____ (Print Title)

Employer Representative Signature: _____ Date: _____

Instructions to Complete the Enrollment Adjustment Form

Section A: Agency and Employee Information (Complete all of Section A.)

Section B: Action/Reason

Effective Date is:

- New Hire = First day of participation in the Plan. Plan Year start date for Annual Enrollment.
- Family Status Change = First of the month following the event.

Check the appropriate box and, if applicable, enter the information requested.

New Hire - refers to initial eligibility (within a certain number of days from employment date).

Re-Hire - refers to participant who is rehired within the same Plan Year.

Contact Info Adjustment - skip Sections C and D.

Qualifying Life Event - refers to an eligible event that allows a reimbursement account enrollment or change within 30 days after the event date. Mark the QLE box and enter the correct Reason Code and Event Code. The Reason Codes are listed on the following chart. The only qualifying events that may be used to drop Flexible Spending Health are the death of a dependent or Family Medical Leave Act (FMLA).

You may notify your Benefits Coordinator when you have a family status change.

Qualifying Life Event (QLE) Reference Table

Event	Qualifying Life Events Example	Reason
Employee marital status change	Marriage Divorce or Annulment Death of a Spouse	MAR DIV DOD
Dependent status change	Birth of a new dependent Adoption/Foster placement of new dependent Employee gains or loses dependent(s) through death Dependent becomes eligible or loses eligibility for insurance coverage Other (X) child moves out Dependent gets married	BIR ADP DOD DEP XMO DGM
Employment status change	Employee/Dependent employment status change Dependent becomes eligible	ESC DPE
Significant change in cost/ coverage imposed by third party	Significant cost change by day care provider Significant change in cost/coverage of dependent's health plan Significant change in cost/coverage of dependent's dental plan	SCC SCC SCC
Court ordered coverage change	Employee gains requirements to provide coverage for child/spouse Employee denied requirements to provide coverage for child/spouse	MSO MSD

Section C: Please indicate the Benefits changes or terminations you wish to make.

Section D: Authorization

Read section carefully. Sign & date the PowerFlex Flexible Spending Account Enrollment Adjustment form; return to your Benefits Coordinator.

Participation Rules

I understand that reimbursement account eligibility and benefits information is available from my Benefits Coordinator. I authorize payroll deductions for the benefits elections indicated on the Enrollment Adjustment Form. I must make election changes no later than 60 days after the date a Qualifying Life Event (QLE) occurs if I want to enroll in a reimbursement account or change my reimbursement account elections or amounts and that any requested election change must be consistent and in line with the QLE. I must file all claims eligible for reimbursement by the last day of the Plan Year or Plan Year's Runout Period, in order to utilize any remaining balance from my account(s). Any amounts remaining in my reimbursement account(s) after the end of the Plan Year or Plan Year's Runout Period, will be forfeited.

