

Flexible Spending Account Change/Termination Form

Please complete, sign and date this form so that we can change your Flexible Spending Account information.

Employee Information	
Employer/Company:	
Employee's Name:	
Social Security #:	

- Terminate Employee Participation: (Date) _____
 Delete Participation in Benefit – Date Effective: _____
 Employee Name Change: New Name: _____

	Old Amount Per Pay Period	New Amount Per Pay Period
1. Health Care Spending Account	\$	\$
2. Dependent Care Spending	\$	\$
Total New Deductions	\$	\$

Employee's Reason for Change	Date of Change
Marriage/Divorce	
Dependent Care Account (amount increase or decrease; provider change)	
Birth or Adoption of Child	
Death of Spouse or Dependent	
Dependent satisfies (or ceases to satisfy) dependent eligibility requirements	
Change in Status of Employment: Type: _____	
Change in Spouse's Employment: Type: _____	
Unpaid Leave of Absence of Employee or Spouse: Dates: From _____ to _____	

You must sign and date this form in order for us to update your information.

I, the undersigned employee, do certify the above changes have occurred. I authorized the changes I have noted as well as the payments required for those changes under the Section 125 Plan. I understand that the above changes are effective for the remainder of the plan year unless I experience a recognized change in status as noted above.

Employee's Signature

Date

**** Changes or termination of plan will be effective only upon Employer confirmation ****

For Company Office Use Only

Effective Date of Change: _____

Effective Pay Period Date: _____

Authorized Signature: _____

Date: _____