Flexible Benefits Plan Change Form

Flexbene
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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): X X X ■ X X ■
Address:	City, State, Zip code

Employee Personal Data Change (Please Print)

☐ Employee Name Change:
(Former Name)

Select Eligible Change Event Below:

☐ Employee Termination	Event Date:
☐ Spouse Employment Change	Event Date: (PT or FT, Hours, Days of Week)
☐ Participant's Legal Marital Status	Event Date: Type of Change: (Divorce, Married, Separated, Other)
☐ Number of Tax Reported Dependents	Detail:
☐ Work Schedule	New Work Schedule: (PT or FT, Hours, Days of Week)
☐ Residence Update	New Address:
☐ Dependent Satisfies/Ceases to Satisfy Dependent Eligibility Requirements	Detail:
☐ Dependent Care Cost or Provider (DC Only)	Care Provider Name and Cost Change: (MUST Complete NEW DC Registration Statement):
☐ Other: (Provide Explanation)	Detail:

	New **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: _____