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): 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:

☐ 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	Care Provider Name and Cost Change: (MUST Complete NEW DC Registration Statement):
☐ I no longer have Dependent Care services	Reason:
☐ Other	Reason:

	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 (Admin Use Only): _____