Qualifying Change in Status Form
HCRA and DCRA

State Employees' Flexible Benefits Plans
PO Box 304900
Montgomery AL 36130-4900
334.263.8312 1.866.833.3378 Fax: 334.263.8512

Employee Information

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Contract Number</th>
</tr>
</thead>
</table>

Home Phone: (            ) Work Phone: (            )

Reason for Change(s) in Flexible Benefit Account
Place a check next to the statement that best describes the reason for this action and give the date of the qualifying event.

Date of Qualifying Event ____________________________

- Addition of dependent(s) through marriage, birth or adoption of a child, legal custody or placement for adoption;
- Loss of dependent(s) through divorce, annulment, legal separation, death of a spouse or other dependent, or loss of legal custody;
- Unpaid leave of absence for you or your spouse;
- Termination or commencement of your spouse's or dependent's employment;
- Change from full-time to part-time or part-time to full-time by the employee, spouse or dependent;
- Change from hourly to salaried payroll status or vice versa;
- Any other change in employment status not listed that results in the gain or loss of eligibility of the employee, spouse, or dependent;
- Dependent's loss of coverage due to age;
- Change of residence or worksite of employee, spouse or dependent;
- Change in the cost of day care;
- Compliance with issuance of family relations judgment, decree or order (i.e., QMCSO);
- Medicare or Medicaid entitlement of employee, spouse or dependent;
- Taking leave under the Family and Medical Leave Act;
- To make changes in the IRC Section 401(k) and 401(m) elective and after-tax deferrals as permitted by those sections;
- HIPAA Special Enrollment events;
- Significant change in medical benefits or premiums.

Dependent Information
Specify each eligible dependent to be covered, if applicable

<table>
<thead>
<tr>
<th>Dependent’s Full Name</th>
<th>Social Security Number</th>
<th>DOB</th>
<th>Relationship</th>
</tr>
</thead>
</table>

Coverage Changes

<table>
<thead>
<tr>
<th>Dependent Care Reimbursement</th>
<th>Health Care Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase contribution from $</td>
<td>Increase contribution from $</td>
</tr>
<tr>
<td>to $</td>
<td>to $</td>
</tr>
<tr>
<td>Decrease contribution from $</td>
<td>Decrease contribution from $</td>
</tr>
<tr>
<td>to $</td>
<td>to $</td>
</tr>
<tr>
<td>Discontinue DCRA</td>
<td>Discontinue HCRA</td>
</tr>
</tbody>
</table>

Certification: I understand that the Internal Revenue Code prohibits me from changing the election I have made after the beginning of the Plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify that the information furnished in this form is true and complete to the best of my knowledge.

____________________________  ______________________
Employee Signature            Date