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

Last First MI	Contract Number
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

Dependent's Full Name	Social Security Number	DOB	Relationship

Coverage Changes

Dependent Care Reimbursement	Health Care Reimbursement
_____ Increase contribution from $_____ to $_____	_____ Increase contribution from $_____ to $ _____
_____ Decrease contribution from $_____ to $_____	_____ Decrease contribution from $_____ to $_____
_____ Discontinue DCRA	_____ Discontinue HCRA

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