

Qualified Status Change Form



Febco Benefits Administration

Participant Information

Employer Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____ Birthday: _____

Change in Status: *(Check all that apply)*

Date Event Occurred: _____

Change in legal marital status Birth of a child. Death of a dependent. Adoption of a child

Change in dependent eligibility Day care rate changes by 10% or more, you enrolled your child in a different plan.

Employment status change that affects eligibility for health insurance benefits for you, your spouse or any dependent . Change in coverage. For DCA only, change in daycare provider

Change in residence required by my employer affecting eligibility (i.e. moving to an area that would require you select a new or other insurance plan) Other (please explain) _____

Incomplete forms will not be processed

As a result of the status change indicated above on this form, I am requesting the following:

To replace my current election with a new election. I understand that only expenses incurred on or after the date of my qualifying event are eligible for reimbursement with my new election. I now choose to CANCEL my current election and replace it with the following amount for the remainder of this plan year.

Elect to participate: I wish to begin participation in a pretax benefit account for the remainder of this plan year.

Cancel my current election.

Account Type: _____ Old Per pay amount: \$ _____ New Per pay amount: _____

Signature *(Incomplete forms will not be processed)*

Employee Signature: _____ Date: _____

Fax this form to: (502) 695-9692

Febco Benefits Administration
PO Box 5010
Frankfort, KY 40602

www.febco.com

Form: STATUSCHANGE03252015

Customer Service: 1-800-489-1539