

**Email to:** [Flex@hng.com](mailto:Flex@hng.com)  
**Fax to:** 866-600-7398 or 225-644-9985

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**Effective Date of Status Change**

_____ <i>Employee Name</i>	_____ <i>Employer</i>
_____ <i>Address</i>	_____ <i>Telephone</i>
_____ <i>City</i>	_____ <i>State</i> <span style="float: right;"><i>Zip</i></span>
_____ <i>Social Security Number</i>	

**Change in Status:**

(Check One)

- Marriage, Divorce, Legal Separation or Annulment
- Birth, Adoption, or Placement of adoption of your child Death of your spouse or dependent
- Changes in the employment status of you or your spouse or dependent, including:
  - Commencement or termination of employment, strike, lockout, unpaid leave of absence, change in work site, or switch from salaried to hourly paid
- Entitlement to COBRA continuation coverage  
Entitlement to Medicare or Medicaid
- Receipt by the plan of a Qualified Medical Child Support Order (QMCSO) pertaining to your dependent child
- Change in residence by you or your spouse or dependent affecting eligibility Unpaid leave of absence
- USERRA: Uniformed Services Employment or Reemployment Rights Act.

As a participant in the Medical FSA program, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in family status.

I understand that the change in my benefit election must be necessitated by and consistent with the change in family status and that change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have experienced the preceding change in status.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_