HealthTrust
Benefit Advantage

Flexible Benefits Plan Change-in-Status Form

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EMPLOYEE INFORMATION (Please Print)

First Name_____ Last Name _____ MI _____ Gender _____

Date of Birth_____ Marital Status _____ Home Telephone_____

Employer _____ Work Telephone _____

Email _____ Mailing Address _____

City _____ State _____ Zip_____

As a participant in the Flexible Spending Plan, I understand that I may make an election change if, under the facts and circumstances, (i) a "Change-in-Status event" occurs, and (ii) the requested election change satisfies the consistency rules set forth in the Plan Document.

I certify that I have incurred the following change in status, and that the requested change is on account of and consistent with the Change-in-Status event checked below:

- ☐ Legal Marital Status (marriage, death of a spouse, divorce, legal separation)
- ☐ Number of Dependents (birth, adoption, or death of a dependent)
- ☐ Employment Status (changes in employment status of employee or spouse such as termination, commencement of employment or a change in work schedule, e.g., a switch between part-time and full-time employment)
- ☐ Unmarried Dependents (dependent now satisfies or ceases to satisfy requirements for coverage due to age, student status or other circumstances)
- ☐ Residence (change in place of residence or work of the employee, spouse, or dependent)
- ☐ Significant change in coverage or cost under my or my spouse's plan (does not apply to Health Flexible Spending Account)
- ☐ Other _____ (must be permitted by IRS rules and the Plan Document)

TERMINATION

I hereby request and authorize my employer to terminate my participation in the following benefit(s):

- ☐ Health Flexible Spending Account — Effective Date _____ — Last Payroll Date _____
- ☐ Dependent Care Reimbursement Account — Effective Date _____ — Last Payroll Date _____

CHANGE

I hereby request and authorize my employer to change my participation in, and salary reduction amount for, the remainder of this Plan Year as follows:

☐ Health Flexible Spending Account — Effective Date of Change _____

$_____ (Current amount being deducted per pay period) x _____ (# of pay periods to date) = $_____ ("To-date" contributions)

$_____ (New amount to be deducted per pay period) x _____ (# of pay periods remaining in Plan Year) = $_____ (New election amount)

☐ Dependent Care Reimbursement Account — Effective Date of Change _____

$_____ (Current amount being deducted per pay period) x _____ (# of pay periods to date) = $_____ ("To-date" contributions)

$_____ (New amount to be deducted per pay period) x _____ (# of pay periods remaining in Plan Year) = $_____ (New election amount)

NOTE: "To-date" contributions plus new election amount must not exceed Plan Year maximum.

(continued on reverse side)

SALARY REDUCTION AGREEMENT AND SIGNATURE

I understand and agree to the following:

- The total amount(s) stated on reverse side will be deducted from my paychecks on a pre-tax basis. I understand that this will lower my gross pay and, consequently, Social Security earnings for tax purposes.
- These election amount(s) replace any previous information or election.
- The minimum/maximum election amounts have been previously communicated to me by my employer.
- I must continue enrollment in the Plan, with my above-stated salary reduction amount(s), until the end of the Plan Year or my employment termination date, whichever occurs first. However, I may be allowed to change or revoke my salary reduction amount(s) in accordance with plan rules in the event of another change in my family or employment status (e.g., marriage, divorce, birth, paid or unpaid leave of absence, change in hours).
- IRS regulations stipulate a “use-or-lose” rule that requires participants to use all of their designated FSA funds during the plan year (or during the 2½-month grace period immediately following the plan year, if elected by your employer), or forfeit remaining balances. Some employers offer an option of a carryover up to the allowed IRS maximum limit for the Health FSA, in place of the optional grace period. Check with your employer on your plan’s specifics. You have up to 90 days after the period of coverage ends to submit claims incurred during the period of coverage.
- Healthcare FSAs will reimburse IRS-eligible healthcare expenses up to my annual election amount (minus any previous payment).
- Dependent Care Accounts will reimburse IRS-eligible dependent care expenses only up to my account balance at the time of my request.

Employee Signature _____ Date _____

Employer Signature_____ Date _____