

# New Hire and Change of Status Form

Request for Election Change Due to a Qualifying Change of Status or New Hire

**Please Submit Promptly to ProBenefits – Fax (877) 761-1850**

Company/Organization: \_\_\_\_\_

Name of Participant: \_\_\_\_\_ Social Security # : \_\_\_\_\_

Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Election changes generally cannot be retroactive and must be consistent with the qualifying event.

## 1) Reason for Change

<input type="checkbox"/> <b>New employee now eligible for insurance</b> - Employee must also complete a Plan Participation Form	
<input type="checkbox"/> Elect Cobra	<input type="checkbox"/> Family Dependent Status Change
<input type="checkbox"/> Marriage	<input type="checkbox"/> Change from Full-Time to Part-Time
<input type="checkbox"/> Divorce	<input type="checkbox"/> Dependent Care Rate Change
<input type="checkbox"/> Birth or Adoption of a Child	<input type="checkbox"/> Change in pay frequency
<input type="checkbox"/> Death of a Spouse or Child	<input type="checkbox"/> Change in deduction frequency
<input type="checkbox"/> Employment of Spouse	<input type="checkbox"/> Accounting Correction
<input type="checkbox"/> Termination of Spouse Employment	<input type="checkbox"/> Back from Leave of Absence
<input type="checkbox"/> Away on Leave of Absence	
Other: _____	

## 2) Change Please change my current Flexible Benefits Plan election as follows:

Action*	Type of Coverage	Payroll Frequency**	EE contribution per pay period	ER contribution per pay period	First Payroll Date Impacted
	<b>Medical FSA</b>		\$	\$	
	<b>Dependent FSA</b>		\$	\$	
	<b>Health Insurance</b>		\$	\$	
	<b>Dental Insurance</b>		\$	\$	
			\$	\$	
			\$	\$	

\*Indicate Action as one of the following: **A**=Add a Coverage, **C**=Change a Coverage, **D**=Drop a Coverage

\*\*Indicate payroll frequency (**M**onthly, **B**iWeekly, **S**emi-Monthly, **W**eekly, **48X**/yr.)

## 3) Certification

If the Plan Administrator deems the qualifying event meets the consistency standards according to the IRS Code, I wish to revoke my existing Flexible Benefit Plan election and make a new election for the remainder of the current plan year as shown above.

Employee Participant

Employer Plan Administrator

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Attention Plan Administrator: Please consult [Status Changes](#) in the online Administrators Guide or your ProBenefits Administrator to verify whether or not the requested change meets the appropriate IRS and Plan guidelines.

**ProBenefits**