



**Bismarck State College Flex Comp Plan
STATUS CHANGE FORM**

This form must be submitted within 30 days of the event.

Employee Name: _____ Empl ID: _____ Date of Status Change (mm/dd/yy): _____

Type of Status Change: (Please indicate one of the following)

You may request a change in your election to revoke the existing plan election and make a new election for the remainder of the plan year. Please complete the form and submit to the Payroll Office within 30 days of the change in status. The Payroll Office will review your request and made a determination as to whether the request is appropriate in accordance with IRS regulations. The date the change goes into effect must be prospective. Retroactive elections are not allowed.

- Change in Legal Marital Status :** Events that change an employee's legal marital status, including the following: marriage, death of spouse, divorce, legal separation and annulment.
- Number of Dependents :** Events that change an employee's number of dependents including the following: birth, death, adoption and placement for adoption. A dependent is formally defined to be a tax dependent under Code Section 152. his rule would not allow election changes for non-tax dependents such as parents, domestic partners and children of domestic partners.
- Dependent Satisfies or Ceases to Satisfy Eligibility Requirements :** Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance.
- Employment Status :** Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent: A termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. Also included is if an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan.
- Residence :** A change in the place of residence of an employee, spouse or dependent.

Other Allowed Change Events:

- Change in day care provider
- Change in cost of day care provider (Does not apply when the day care provider is a relative)

Based on the above Status Change, please change my annual election as follows:

Indicate Flexible Spending Account change:

	Previous Annual Election (Total)	New Annual Election (Total)
Medical Spending Account	\$ _____	\$ _____
Dependent Care Spending Account	\$ _____	\$ _____

- Elect Premium Conversion for: _____
- Revoke Premium Conversion for: _____

I have read and fully understand the regulations to change my election. I understand that this Status Change Form must be completed within 30 days of the change in status event and the election change I have requested must be consistent with the change in status event. I understand retroactive election changes are not allowed and that my election change will be effective on the later of the Election Date or Date of Status Change. I certify that the above information is true and correct, and agree to provide any necessary third-party documentation to verify the change in status event.

Requested by:
Participant Signature: _____ Date: _____

Reviewed by:
Employer Signature _____ Date: _____

- Approved
- Denied