Mail To:
ABA, Inc.
P. O. Box 10787
Burbank, CA 91510
(818) 842-0147

FSA – Change In Status Election Form

Plan Sponsor Name: _____

Employee Name: _____

Employee Address: _____

Soc. Sec. No.: _____ Date of Birth: _____

As a participant in the Cafeteria Plan, I am entitled to change my benefit election in the event of certain changes in status.

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

I certify that I have incurred the following change in status:

_____ Birth, Adoption or Placement for adoption of a child

_____ Death of my spouse and / or a dependent

_____ Divorce, Legal Separation of Annulment

_____ Marriage

_____ Termination or commencement of employment by my spouse or dependent

_____ My spouse / dependent or I have taken an unpaid leave of absence

_____ My spouse / dependent or I have a change in the residence or worksite

_____ My dependent satisfies or ceases to satisfy the requirements for coverage

_____ Change is work status (part-time to full time or vice-versa, reduction or increase in hours, strike or lockout)

_____ Other: _____

The Administrator may require evidence to document the event which effected the change in election.

_____ _____

Employee's Signature Date

_____ _____

Administrator's Signature Date