



*Employee Information*

Employer Name \_\_\_\_\_

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Change: \_\_\_\_\_

*Nature Of Change*

- Enroll in Dependent Care Expense Account
- Change Dependent Care pre-tax deduction amount (complete Part 4 below)
- Discontinue participation in Dependent Care Account

*Qualifying Life Status Change*

- Change in marital status
- Change in number of dependents
- Spousal employment or coverage:  changed  terminated
- Change in number of work hours for:  self  spouse or dependent
- Change of work site
- Change of residence
- Dependent no longer qualifies as a dependent
- Day care provider cost of care:  increased  decreased
- Other: \_\_\_\_\_  
(Explanation required)

*Authorization*

I have reviewed the terms of my Employer's Flexible Benefits Plan. I understand that the changes I direct on this form will be deducted from my compensation on a pre-tax basis and the deductions cannot be changed until the next plan year unless there is a qualifying change in status. I have read and agree to the terms of participation. I authorize my employer to change my contribution to the following amount:

\$ \_\_\_\_\_ per pay period x \_\_\_\_\_ remaining pay periods = \$ \_\_\_\_\_ Remainder of Plan Year Total

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

For Employer Use Only:					
Company Name:	Division:	Effective Date:	Pay Cycle:	Entered in Payroll:	Initials: