Change of Status Form

Effective Payroll: _____

Employer Name: _____

Employee Name: _____ Last 4 SSN: _____

Phone: _____ E-Mail: _____

Qualifying Event

☐ Marriage

☐ Divorce

☐ Birth of a child

☐ Adoption of a child

☐ Death of a child

☐ Death of a spouse

☐ Change in Cost or Coverage of Health Insurance Plan*

☐ Change of spouse's employment

☐ Change of employee's employment status

☐ Change in Residence*

☐ Other (please specify)

_____

Termination Date (if applicable): _____ Leave Date (if applicable): _____

*Does not apply to Healthcare FSA.

Please make the benefit selection changes as indicated above. The change requested must be consistent with and due to the qualifying event shown above.

ADD/DROP/CHANGE	BENEFIT	OLD ELECTION	CHANGE AMT. (+/-)	NEW ELECTION	EFECTIVE DATE

This form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a qualifying status change. The information furnished above is accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Mail: 6939 Sunrise Blvd., Ste. 250, Citrus Heights, CA 95610

Phone: (866) 446-1072 Fax: (916) 221-5040 E-Mail: transactions@tdsplans.org