FLEXIBLE BENEFITS PLAN
STATUS CHANGE FORM

I certify that I have had a change in family status that requires a change in my election of benefits under the Internal Revenue Code Section 125 (Flexible Benefits Plan), this change in family status meets the Consistency Rule outlined in the Plan document, and this change form has been submitted within 30 days of the change.

The effective date is _____/_____/_____ and the status change is for the following:

Qualifying Events for: Premium Only, Health Care Spending Account, and/or Dependent Care Spending Account — By checking the box(es) below I certify that I have incurred a change in status as indicated.			
☐ Premium Only	☐ Health Care FSA	☐ Dependent Care FSA	**Change in Legal Marital Status:** ☐ Marriage; ☐ Divorce; ☐ Legal separation; ☐ Annulment.
☐ Premium Only	☐ Health Care FSA	☐ Dependent Care FSA	**Change in the number of tax dependents:** ☐ Birth; ☐ Adoption; ☐ Placement for adoption; ☐ Death of a spouse or dependent.
☐ Premium Only	☐ Health Care FSA	☐ Dependent Care FSA	**Change in employment status of the employee, employee's spouse or employee's dependent(s):** ☐ Termination or commencement of employment; ☐ Strike or lockout, ☐ Commencement of, or return from an unpaid leave of absence, ☐ A switch between part-time and full-time employment; ☐ A change in worksite.
☐ Premium Only	☐ Health Care FSA	N/A	**Change in eligibility or ineligibility of spouse or dependent:** ☐ Due to attainment of limiting age under the insurance plan; ☐Gain or loss of student status; ☐ Marriage or any similar circumstance.
☐ Premium Only	☐ Health Care FSA	N/A	**Residence change of the employee, employee's spouse, or employee's dependent(s):** Only allowable if the change in residence affects the employee's eligibility for coverage.
☐ Premium Only	☐ Health Care FSA	N/A	**A Judgement, Decree or Court Order**: resulting from divorce, legal separation, annulment or change in legal custody including a Qualified Medical Child Support Order that requires an insurance coverage change for the employee's dependent(s).
☐ Premium Only	N/A	N/A	**Eligibility for Medicare or Medicaid:** If the employee, spouse, or dependent becomes eligible for Medicare or Medicaid or ceases to be eligible for Medicare or Medicaid.
☐ Premium Only	N/A	☐ Dependent Care FSA	**Additional Qualifying Events:** ☐ Significant cost increases; ☐ Significant coverage curtailment; ☐ Addition or elimination of benefit package options offered by your employer; ☐ Change in coverage of spouse or dependent under another employer's plan; ☐ Family Medical Leave of absences as qualified under FMLA, HIPAA special enrollment rights, qualification and election under COBRA or state continuation.

Printed Name: _____   Social Security # _____

Signature: _____   Date: _____

Return this form along with your updated enrollment form to the LSU AgCenter, HRM Office
PO Box 25203 Baton Rouge, LA 70894 or Room 103 J.N. Efferson Hall, LSU Campus, Baton Rouge, LA 70803