



**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.			
<input type="checkbox"/> Premium Only	<input type="checkbox"/> Health Care FSA	<input type="checkbox"/> Dependent Care FSA	Change in Legal Marital Status: <input type="checkbox"/> Marriage; <input type="checkbox"/> Divorce; <input type="checkbox"/> Legal separation; <input type="checkbox"/> Annulment.
<input type="checkbox"/> Premium Only	<input type="checkbox"/> Health Care FSA	<input type="checkbox"/> Dependent Care FSA	Change in the number of tax dependents: <input type="checkbox"/> Birth; <input type="checkbox"/> Adoption; <input type="checkbox"/> Placement for adoption; <input type="checkbox"/> Death of a spouse or dependent.
<input type="checkbox"/> Premium Only	<input type="checkbox"/> Health Care FSA	<input type="checkbox"/> Dependent Care FSA	Change in employment status of the employee, employee's spouse or employee's dependent(s): <input type="checkbox"/> Termination or commencement of employment; <input type="checkbox"/> Strike or lockout, <input type="checkbox"/> Commencement of, or return from an unpaid leave of absence, <input type="checkbox"/> A switch between part-time and full-time employment; <input type="checkbox"/> A change in worksite.
<input type="checkbox"/> Premium Only	<input type="checkbox"/> Health Care FSA	N/A	Change in eligibility or ineligibility of spouse or dependent: <input type="checkbox"/> Due to attainment of limiting age under the insurance plan; <input type="checkbox"/> Gain or loss of student status; <input type="checkbox"/> Marriage or any similar circumstance.
<input type="checkbox"/> Premium Only	<input type="checkbox"/> 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.
<input type="checkbox"/> Premium Only	<input type="checkbox"/> 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).
<input type="checkbox"/> 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.
<input type="checkbox"/> Premium Only	N/A	<input type="checkbox"/> Dependent Care FSA	Additional Qualifying Events: <input type="checkbox"/> Significant cost increases; <input type="checkbox"/> Significant coverage curtailment; <input type="checkbox"/> Addition or elimination of benefit package options offered by your employer; <input type="checkbox"/> Change in coverage of spouse or dependent under another employer's plan; <input type="checkbox"/> 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