



Change of Status Election Form

Return this completed form to:
Mail: MidAmerica Administrative & Retirement Solutions
PO Box 149, Lakeland, FL 33802-0149
Email: Forms@myMidAmerica.com | Ph: (800) 430-7999

A change of election must be on account of and corresponding to a change in status that affects eligibility for coverage or expenses as acceptable under Regulations issued by the Department of Treasury. The change of status must be made within 30 days of the qualifying event.

STEP 1 PARTICIPANT INFORMATION

Employer			Social Security Number	
First Name	Last Name	M.I.	Date of Birth (MM/DD/YYYY)	
Mailing Address		City	State	Zip
Email Address			Telephone	

STEP 2 TYPE OF CHANGE

NOTE: Enter effective date of coverage: _____

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year will be forfeited. Expenses/claims must be incurred during the Plan Year in order to be eligible for reimbursement. See the Summary Plan Description for more details.

BENEFIT	CURRENT ANNUAL ELECTION	CURRENT PER PAY PERIOD WITHHOLDING	NEW ANNUAL ELECTION	NEW PER PAY PERIOD WITHHOLDING
Health Care Reimbursement	\$ _____	\$ _____	\$ _____	\$ _____
Dependent Care Reimbursement	\$ _____	\$ _____	\$ _____	\$ _____

STEP 3 REASON FOR CHANGE (QUALIFYING EVENT)

NOTE: Enter date of change in status* _____

Valid qualifying events (QE) include, but not limited to:

- Change in employment status (beginning/end of employment of a spouse resulting in gain or loss of insurance coverage)
- Change in your legal marital status (marriage, divorce, death of spouse)
- Change in number of tax dependents (birth, adoption/placement for adoption, gain/loss of dependent eligibility, death of dependent)
- Change in coverage, cost or provider. This applies only to Dependent Care.
- Gain or loss of other group health coverage (Medicare/Medicaid, COBRA)
- Judgement, decree or court order
- Unpaid leave of absence
- Change from part-time to full-time employment status or vice versa

*Please note: You must make your election within 30 days of the qualifying event.

Please note: You must submit supporting documentation corresponding with the QE such as marriage, death, or birth certificate; divorce decree; letter from employer or childcare provider substantiating employment status or change in coverage, cost or provider, respectively.

STEP 4 PARTICIPANT CERTIFICATION & SIGNATURE

I hereby am amending my Flexible Benefits Plan election; therefore, I authorize my Employer to reduce my wages on a pretax basis during each payroll period in the amount noted above. I understand this election will be in effect for only the current plan year. I understand I must complete each year.

I understand that I cannot revoke or change this election during the Plan Year unless there is another change in status qualifying event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description.

I understand that I must submit a claim and appropriate substantiating documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Account Plan for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Participant Signature	Signature Date (MM/DD/YYYY)
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