

MOUNT HOLYOKE

QUALIFIED STATUS CHANGE EVENT FORM

Name: _____ Social Security #: _____

Home Address: _____

Pay Frequency: Monthly _____ Biweekly _____

My Qualified Status Change Event occurred on _____
(Date of Change)

Check One:

- Status change events (must additionally satisfy consistency rule)
 - change in legal marital status
 - change in number of dependents
 - change in employment status (you or spouse)
 - change in work schedule (you or spouse)
 - change in residence or worksite (you or spouse)
 - dependent satisfies/ceases to satisfy dependent eligibility requirements
- Judgment, decree, or court order
- Entitlement to Medicare or Medicaid
- Significant change in benefits coverage (i.e. changes to health insurance plan results in increase in co-pays)
- Change in the cost of child care provider
- COBRA Qualifying Event
- FMLA Leave
- Loss of other health insurance coverage

Check the appropriate spaces:

I hereby **terminate** my benefit election and compensation reduction agreement under the *Mount Holyoke College* Flexible Benefit program with respect to the following individual plans for the reason shown above:

<u>Election(s) to Terminate</u>	<u>Total YTD Contributions</u>
<input type="checkbox"/> Health Care Spending Account	\$ _____
<input type="checkbox"/> Dependent Care Spending Account	\$ _____

I hereby **change** my benefit election and compensation reduction agreement under the *Mount Holyoke College* Flexible Benefit program with respect to the following individual plans for the reason shown above:

<u>Election(s) to Change</u>	<u>New Annual Election</u>	<u>Per Pay Deduction</u>
<input type="checkbox"/> Health Care Spending Account	\$ _____	_____
<input type="checkbox"/> Dependent Care Spending Account	\$ _____	_____

Employee Signature

Date

Human Resources Representative

Date