

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan

P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150

334-517-7000 or 877-517-0020

Web site: www.rsa-al.gov



In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name
Mailing Address	City		State ZIP Code
Date of Birth ____/____/____	Home Phone ____-____-____	Work Phone ____-____-____	
Marital Status			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed			

Reason for Status Change

I certify that I have incurred the following change in status:

- | | |
|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Significant change in medical benefits or premiums |
| <input type="checkbox"/> Marriage of dependent | <input type="checkbox"/> Termination of spouse/dependent employment |
| <input type="checkbox"/> Birth of a child | <input type="checkbox"/> Commencement of spouse/dependent employment |
| <input type="checkbox"/> Adoption of a child | <input type="checkbox"/> Taking leave under the Family and Medical Leave Act |
| <input type="checkbox"/> Legal custody of a child | <input type="checkbox"/> Medicare/Medicaid entitlement |
| <input type="checkbox"/> Divorce/annulment | <input type="checkbox"/> Unpaid Leave of Absence |
| <input type="checkbox"/> Death of spouse/dependent | <input type="checkbox"/> Short plan year |
| <input type="checkbox"/> Dependent loss of coverage | |

Date qualifying event occurred (Required) ____/____/____

Note: PEEHIP must be notified within 45 days of the occurrence of the qualifying event.

Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request:

Note: Cannot be less than the amount already payroll deducted or paid in reimbursements.

- New Annual Election Amount \$ _____ × 12 months = \$ _____ Annual Amount
Maximum amount cannot exceed \$5,000 and the minimum annual amount is \$120.
- Stop Payroll Deductions

Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested:

Note: Cannot be less than the amount already payroll deducted or paid in reimbursements.

- New Annual Election Amount \$ _____ × 12 months = \$ _____ Annual Amount
Maximum amount cannot exceed \$5,000 if single or married filing a joint return, \$2,500 if married filing separate returns. The minimum annual amount is \$120.
- Stop Payroll Deductions

PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature _____ Date Signed ____/____/____