

## 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](http://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						
<i>Name must be entered as shown on your Social Security card.</i>						
Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name			
Mailing Address		City		State		
Date of Birth ____/____/____		Home Phone ____-____-____	Work Phone ____-____-____	Email Address		
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:						
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Marriage  <input type="checkbox"/> Marriage of dependent  <input type="checkbox"/> Birth of a child  <input type="checkbox"/> Adoption of a child  <input type="checkbox"/> Legal custody of a child  <input type="checkbox"/> Divorce/annulment  <input type="checkbox"/> Death of spouse/dependent  <input type="checkbox"/> Dependent loss of coverage                             </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Significant change in medical benefits or premiums  <input type="checkbox"/> Termination of spouse/dependent employment  <input type="checkbox"/> Commencement of spouse/dependent employment  <input type="checkbox"/> Taking leave under the Family and Medical Leave Act  <input type="checkbox"/> Medicare/Medicaid entitlement  <input type="checkbox"/> Unpaid Leave of Absence  <input type="checkbox"/> Short plan year                             </td> </tr> </table>					<input type="checkbox"/> Marriage <input type="checkbox"/> Marriage of dependent <input type="checkbox"/> Birth of a child <input type="checkbox"/> Adoption of a child <input type="checkbox"/> Legal custody of a child <input type="checkbox"/> Divorce/annulment <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Dependent loss of coverage	<input type="checkbox"/> Significant change in medical benefits or premiums <input type="checkbox"/> Termination of spouse/dependent employment <input type="checkbox"/> Commencement of spouse/dependent employment <input type="checkbox"/> Taking leave under the Family and Medical Leave Act <input type="checkbox"/> Medicare/Medicaid entitlement <input type="checkbox"/> Unpaid Leave of Absence <input type="checkbox"/> Short plan year
<input type="checkbox"/> Marriage <input type="checkbox"/> Marriage of dependent <input type="checkbox"/> Birth of a child <input type="checkbox"/> Adoption of a child <input type="checkbox"/> Legal custody of a child <input type="checkbox"/> Divorce/annulment <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Dependent loss of coverage	<input type="checkbox"/> Significant change in medical benefits or premiums <input type="checkbox"/> Termination of spouse/dependent employment <input type="checkbox"/> Commencement of spouse/dependent employment <input type="checkbox"/> Taking leave under the Family and Medical Leave Act <input type="checkbox"/> Medicare/Medicaid entitlement <input type="checkbox"/> Unpaid Leave of Absence <input type="checkbox"/> Short plan year					
<b>Date qualifying event occurred (Required)</b> ____/____/____ <i>Note: PEEHIP must be notified within 45 days of the occurrence of the qualifying event.</i>						
Healthcare Flexible Spending Account Information						
Healthcare Flexible Spending Account Change Request:						
<i>Note: Cannot be less than the amount already payroll deducted or paid in reimbursements.</i>						
<input type="checkbox"/> New Annual Election Amount \$ _____ × 12 months = \$ _____ Annual Amount Maximum amount cannot exceed \$5,000 and the minimum annual amount is \$120.						
<input type="checkbox"/> Stop Payroll Deductions						
Dependent Care Flexible Spending Account Information						
Dependent Care Flexible Spending Account Change Requested:						
<i>Note: Cannot be less than the amount already payroll deducted or paid in reimbursements.</i>						
<input type="checkbox"/> 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.						
<input type="checkbox"/> 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 ____/____/____			