NueSynergy

CUSTOMER FOCUSED • TECHNOLOGY DRIVEN

Employee Status Change Form

(Required) 1 through 5 must be completed for all changes

1. Employee's Last Name, First Name, Middle Initial:_____

2. Social Security Number:_____

3. Home Address:_____ State:_____ Zip:_____

4. Home Phone #:_____ Email:_____

5. Employer Group Name:_____

A. Name Change

From:_____ To: _____

B. Employee Status Change

Change in Marital Status

- ☐ Change in legal marital status including marriage, death of spouse, divorce, legal separation and annulment

Change in Number of Tax Dependents

- ☐ Change in the number of tax dependents including birth, adoption, and placement for adoption or death of a dependent

Changes in Spouse or Dependent's Eligibility Under an Employer's Plan

- ☐ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent
- ☐ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence
- ☐ Change in eligibility due to change in residency of the employee, spouse or dependent

Change in Cost or Coverage

(Applicable for dependent care assistance and transportation/parking account elections only)

- ☐ Significant cost increase in your or your dependent's coverage
- ☐ Significant curtailment of your or your dependent's coverage
- ☐ Addition or elimination of benefit package option under your or your dependent's employer's plan
- ☐ Change in coverage or open enrollment of spouse or dependent under other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.
- ☐ Dependent care provider is replaced by another
- ☐ Significant cost increase in your transportation and/or parking expenses
- ☐ Significant curtailment in your transportation and/or parking expenses

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C. Change in Election(s)

Health Care Expense Account

Change my annual election for my Health Care Expense Account from $_____ to $_____
My new per pay period election will be $_____effective with the_____ payroll and a plan effective date of_____

Dependent Care Assistance Program

Change my annual election for my Dependent Care Assistance Program from $_____ to $_____
My new per pay period election will be $_____effective with the_____ payroll and a plan effective date of_____

Dependent Care Assistance Program

Change my annual election for my
Parking Program from $_____ to $_____
Transportation Program from $_____ to $_____

My new per pay period election will be $_____ effective with the_____ payroll and a plan effective date of_____

Employee Signature (Required)

I understand as a participant in the Cafeteria Plan, I am entitled to revoke my prior benefits election and enter into a new election in the event of certain change in status. I understand that the change in benefits election must be due to and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury. I agree to all the changes indicated above.

Employee Signature:_____ Date:_____

Employer Signature (Required)

Employer Authorized Signature:_____ Date:_____

Mail, fax or scan completed form to: NueSynergy Administration Services, 4601 College Blvd, Suite 280, Leawood, KS 66211
Phone: 913.653.8381, Toll-Free: 855.890.7239, Fax: 855.890.7238, E-mail: customerservice@NueSynergy.com

Employer: Keep a copy for your records and provide a copy to the employee