

IBIS 125 Flex Advantage Plan Employee Change of Status Form

Return to: 105/125 Department
800.258.1415 phone
515.286.4244 fax

Iowa Bankers Insurance & Services, Inc
PO Box 6210
Johnston, IA 50131

Employer Name/Location		Billing/Routing Number	
Employee Name		Social Security Number	
Change of Status/Date of Event	Effective Date for Change	Change Date for Payroll Deduction	

I understand that the change in my benefit election must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury. Please refer to your plan document for detailed information on status changes.

Change in Status - Form must be completed within 30 days of event.

I certify that I have incurred the following change which allows me to change my election form:

- Marriage, divorce, legal separation or annulment
- Birth, adoption, or placement for adoption of a child
- Death of my spouse and/or dependent
- Dependent satisfies or ceases to satisfy eligibility requirements due to attainment of age, student status or other similar circumstances (please specify any other similar circumstances below)

- Termination or commencement of my, my spouse's, and/or my dependents employment
- A change in my, my spouse's, or my dependent's employment status with the consequence of becoming or ceasing to be eligible under our respective employer's flexible benefit plan (e.g., if the plan only covers full-time employees, switching from part-time to full-time (or vice versa) constitutes a change in employment status)
- I, my spouse, or dependent have commenced or concluded an unpaid leave of absence
- A change in worksite for me, my spouse, or dependent (if eligibility or dependent care expenses are affected)
- A change in place of residence for me, my spouse, or dependent (if eligibility or dependent care expenses are affected)
- Other _____

Mid-year Reimbursement Account Election Change and Pre-tax Premium Change

Is any part of this election an employer contribution yes no

MedFSA/LFSA (per pay period)	DCAP (per pay period)	Premium (per pay period)
Old Election _____	Old Election _____	Old Election _____
New Election _____	New Election _____	New Election _____

Employee Authorization

I have read and understand the above agreement. I authorize my employer to redirect my salary according to this agreement and I will review my paycheck to verify that my employer has made appropriate withholding consistent with my election.

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with the Plan, and the Administrator has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or under Medicare/Medicaid, or (b) a judgment, decree or order requires an individual other than me to provide accident or health coverage for my child, I certify that such new, improved or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person. If my change in election is denied, I understand that I will have to appeal the decision within the time frame specified in the Summary Plan Description for the Plan. If approved, I hereby elect the change(s) noted above and attest that the change is made on account of and is consistent with the event.

This salary redirection agreement for my reimbursement account(s) and/or the Pre-Tax Premium Payments will continue until:

- I terminate employment with the employer listed above; or
- I have a qualifying status change (see Summary Plan Description) and I modify this agreement consistent with the change; or
- The end of the current plan year or
- My employer terminates, suspends, or modifies this plan or the benefits under the plan

Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____

Revised 3/10



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