Custom Design Benefits

CHANGE Form

Employee Name, Address, Status or Election Amount Change

Employer: *Please scan/email or fax completed form to:*
FAX: (513) 598-2901
EMAIL: customflex@CustomDesignBenefits.com
ONLINE: **www.CustomDesignBenefits.com**

INSTRUCTIONS: Please submit completed form (with new election form if applicable) to your employer. This form must be signed and sent to CDB by your employer in order for changes to be made to your employee records. Please note that your employer may require documentation of events requiring mid-year changes to elections.

Employer: _____ Plan Year Beginning (MM/YY): _____

Employee Name on File: _____ Employee or SSN #: _____

Check Reason for Change:

☐ **Name Change** (Enter New Name Here): _____

☐ **Address Change** (Enter New Address Here): _____

☐ **Termination of Employment**: Effective Date of Termination: _____

Date of Last Payroll Withholding for FSA, HRA or HSA: _____

☐ **Family Status Change** (new payroll election date must be after the family status change date)
I certify that I have or will have incurred the following change in status:

- ☐ Marriage
- ☐ Divorce, Legal Separation or Annulment
- ☐ Birth, adoption or placement for adoption of a child
- ☐ Death of my spouse and/or dependent
- ☐ Termination or commencement of employment by my spouse or dependent
- ☐ Switch from part-time to full-time employment (or vice versa) for me, my spouse or a dependent OR a reduction/increase in hours, strike or lockout
- ☐ Unpaid leave of absence for me, my spouse or dependent
- ☐ Significant change in health coverage due to spouse's employment
- ☐ Change in the residence or worksite of me, my spouse or dependent
- ☐ Dependent satisfies or ceases to satisfy the requirements of health coverage
- ☐ Other: _____

Election Amount Change – Indicate Account Affected & **Attach New Enrollment Form**:
☐ Healthcare ☐ Dependent Care ☐ Parking ☐ Transit ☐ HSA

As a participant in these plans, I am entitled to revoke my prior benefit election and enter a new election in the event of certain changes in status. 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.

Employee Signature: _____ Date: _____

Employer's Authorized Signature: _____ Date: _____

To view claims and other account information visit www.CustomDesignBenefits.com, click Member Portal, then Custom Flex: FSA/HRA/HSA.