Premium, Medical and Dependent Care Reimbursement Change Form

Please PRINT Clearly

Employer	Change Effective Date	No. of Payroll Deductions From Eff Date to End of Plan Year

Employee's First	MI	Last Name	Social Security Number

Employee's Home Street Address	City	State	Zip	Home Phone

BirthDate	Sex	Marital Status	Spouse's Name	Employment Date

Status change: ______ marriage ______ divorce ______ dependent change ______ employment status
Event Date and Details:

I request the following amounts to be deducted pretax:

A. Group Medical Premiums – if you participate in your employer's insurance plan(s), your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department:

Medical Single ____ or Family____ or Revoke _____
Dental Single ____ or Family____ or Revoke _____

B. Health FSA: Revised plan year total _____________, Per paycheck ____________

_____ I revoke my former participation in the healthcare reimbursement account.

C. Dependent Care FSA: Revised plan year total ___________, Per paycheck _______

_____ I revoke my former participation in the dependent care reimbursement account.

I certify I have had an eligible status change/qualifying event within the last 30 days and that my requested election change is consistent with such status change. I request that changes in my reimbursement account be made as indicated.

Signature: ____ Date: ____________

3PAdministrators, 704 Sand Lake Rd., Onalaska, WI 54650 (608) 779-3000 fax (608) 779-3009