

CHANGE IN STATUS (CIS) FORM

Social Security Number		Name (Please Print) Last		First		MI				
Home/Mailing Address			Street		City		State		ZIP Code	

Type Of Change Requested

Change Existing Account (Select accounts you wish to change.)	Start Account (Select accounts you wish to begin.)	Terminate Account (Select accounts you wish to end.)
<input type="checkbox"/> Medical Spending Account*	<input type="checkbox"/> Medical Spending Account*	<input type="checkbox"/> Medical Spending Account*
<input type="checkbox"/> Dependent Care Account	<input type="checkbox"/> Dependent Care Account	<input type="checkbox"/> Dependent Care Account
<input type="checkbox"/> Limited-use Medical Spending Account	<input type="checkbox"/> Limited-use Medical Spending Account	<input type="checkbox"/> Limited-use Medical Spending Account

* Are you currently using the myFBMC CardSM with your MONEYPLU\$ Medical Spending Account? Yes No

Qualified Change Events (Check and date all that apply.)

CIS Effective date of Event	CIS Effective first of the month following Event	Tax Filing Status (please check one)
Event Date Event	Event Date Event	Dependent Care Accounts only
_____ Marriage	_____ Dependent not eligible (marriage, age, loss of dependent status)	<input type="checkbox"/> Married filing separately (maximum - \$2,500)
_____ Birth	_____ Spouse begins Employment	<input type="checkbox"/> Married filing jointly (maximum - \$5,000)
_____ Adoption	_____ Spouse ends Unpaid Leave	<input type="checkbox"/> Single, head of household (maximum - \$5,000)
_____ Placement of Custody	_____ Divorce	
_____ Spouse ends Employment	_____ Legal separation	
_____ Spouse begins Unpaid Leave	_____ Change in Day Care Provider	
CIS Effective day after date of Event	_____ Employee begins Unpaid Leave	
Event Date Event	_____ Employee ends Unpaid Leave	
_____ Spouse passed away	_____ Change from full- to part-time (self, spouse, dependent)	
_____ Dependent passed away	_____ Change from part- to full-time (self, spouse, dependent)	

Payroll Calculation Summary

To be completed by Benefits Administrator	Medical Spending Account	Dependent Care Account	Limited-use Medical Spending Account
A. Current Total Annual Contribution			
B. New Total Annual Contribution			
C. Amount Contributed Thus Far			
D. Amount Needed to Meet New Annual Goal [B minus C]			
E. Number of Paychecks Remaining			
F. New Per-Pay-Deduction Amount [D divided by E]			
Benefit Effective Date (Refer to Qualified Change Events above.)			
Payroll Effective Date			

I certify that on the date(s) indicated, I incurred the Change in Status event(s) selected above and therefore wish to change my plan elections as indicated. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my period of coverage. I understand that the amount of salary deduction will include the items specified above and will continue in effect, unless I terminate employment or file an approved Change in Status with the Benefits Administrator within 31 days of the event. I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any Account or my failure to sign or accurately complete this form. **Current deductions will continue for any accounts that are not changing.**

 Employee Signature	Date
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FOR OFFICE USE ONLY

Signature below affirms that the item(s) checked comply with IRS and Account plan guidelines. This employee meets all eligibility requirements, and is eligible to participate in the MONEYPLU\$ Program. Return processed CIS form via FAX MAIL (check one).

Payroll Center/Agency	Mailing Address	City, State, ZIP Code	Fax Number
Benefits Administrator Approval Signature		Date	Phone Number

Please return within 24 hours of completion. The payroll change should not be made until you receive fax confirmation that the change has been made in Fringe Benefits Management Company's system. Return completed form via fax to 1-850-514-5806 or mail to FBMC, P.O. Box 1878, Tallahassee, FL 32303. If you have questions, you may contact our Customer Care Department, at 1-800-342-8017, for assistance. Please allow up to 10 business days for processing.

Date FBMC Received Approved CIS Form from BA _____ Date FBMC Data Entered CIS Form _____ Date FBMC Sent Processed Form to BA _____