



City of Kettering Change Of Status Form

Election must be made and received by the Plan Administrator within 30 days of the qualifying event.

Section I - Employee Information			
Company Name: CITY OF KETTERING			
Employee Name:		Social Security #	
New Address:	City:	State:	Zip:
Section II - Reason for Change of Election			
<input type="checkbox"/> Marriage - Attach a copy of license Date of Marriage: _____		<input type="checkbox"/> Change of Employee or Spouse's Employment Status ___ Unpaid Leave of Absence ___ Full-time status ___ Strike or Lockout ___ Part-time status ___ Change in worksite ___ Salaried/Hourly Date of change: _____	
<input type="checkbox"/> Divorce/Annulment/Legal Separation – Attach copy of documentation Date of Divorce/Legal Sep: _____			
<input type="checkbox"/> Birth of Child - Attach copy of Birth Certificate Date of Birth: _____		<input type="checkbox"/> Death of Spouse/Dependent - Attach documentation Date of Death: _____	
<input type="checkbox"/> Adoption of Child - Attach copy of documentation Date of Adoption: _____		<input type="checkbox"/> Gain or Loss of Employment By Spouse Date of Hire: _____ Date of Termination: _____	
<input type="checkbox"/> Placement for Adoption of Dependent		<input type="checkbox"/> Termination of Employment Date of Termination: _____	
<input type="checkbox"/> Gain/Loss of Eligibility: ___ Loses eligibility of spouse or dependent ___ Gains eligibility of spouse or dependent		<input type="checkbox"/> Dependent Care Election Changes ___ Change in provider ___ Change in cost of current services	
<input type="checkbox"/> Change in coverage type: HRA or HSA (circle one) ___ Single to family coverage ___ Family to single coverage Effective date of the change: _____		<input type="checkbox"/> Change in FSA or HRA "type": Effective date of the change: _____ ___ Change to General Purpose ___ Change to Limited Purpose ___ Change to Employee Only/Employee + Children ***Must have qualifying event to make this change.***	
Section III - Change of Election Amount			
Complete Prior and Revised Payroll Deductions for the following categories for any change of status.			
Employee Election Category	Current Payroll Deduction Per Pay Period	Revised Payroll Deduction Per Pay Period	
FSA Medical Reimbursement	\$	\$	
FSA Child Dependent Care	\$	\$	
Parking/Mass Transit	\$	\$	
HRA	\$	\$	
HSA	\$	\$	
Date of REVISED Payroll Deduction:		Amount of Last Deduction: \$	
Date of LAST Payroll Deduction:			
<p>This change of election must be accompanied by the appropriate documentation for each of the above changes. You will be advised of the approval or denial of your request for Change in Family Status by your employer. If your change is denied, you will have thirty (30) days in which to respond. If reviewed again and denied, you may pursue other rights accorded you under ERISA. I hereby elect the above changes due to a qualified change in my family status or termination of employment.</p>			
Date _____		Signature of Participant _____ (Participant Signature not required for termination of employment)	
Date _____		Signature of Employer _____	