

**COUNTY OF SANTA BARBARA
FLEXIBLE SPENDING ACCOUNT PLAN**

CHANGE IN STATUS STATEMENT

In addition to completing this form, you must complete a new enrollment form.

Participant Information

Employee Name _____

Social Security Number _____ - _____ - _____

Home Address _____
Street City State Zip

My change in status is: (Choose one)

- _____ Marriage, Divorce or Legal Separation
- _____ Death of a spouse or dependent
- _____ Birth or Adoption of a dependent
- _____ Commencement of your spouse's employment
- _____ Termination of your spouse's employment
- _____ A change from full-time or part-time employment (or vice versa) for you or your spouse
- _____ Unpaid Leave from work for you or your spouse
- _____ A change in your spouse's health plan that makes a substantial difference in your coverage
- _____ Other (explain)

YOU MUST SUBMIT PROOF OF YOUR CHANGE IN STATUS.

Dependent Information

If your change in status is due to marriage or birth or adoption of a dependent, please complete the following:

Spouse/Dependent's (Circle one) Name: _____

Address: _____

Date of Birth: _____

Social Security Number : _____

Spouse's Employer: _____

Spouse's Health Insurance Company or HMO _____

Important – Read carefully before signing

I understand that I may revoke my previous election under the County of Santa Barbara Flexible Spending Account Plan and make a new election for the rest of the period of coverage on account of a change in status, provided that my revocation and new election are consistent with my change in status. I further understand that my change in my election on account of a change in status must be made within 31 days of the date the event occurs.

Employee Signature _____ Date signed _____