Benefit Coordinators Corporation

FSA NOTICE OF ☐ CHANGE / ☐ TERMINATION

Group Information

GROUP NUMBER	GROUP NAME
BB1055	San Diego Community College District

Section I: Employee Information

EMPLOYEE/PARTICIPANT **LAST** NAME	**FIRST**		**MI**	SOCIAL SECURITY NO. / PARTICIPANT ID#: - -
ADDRESS				DATE OF BIRTH ____/____/____
CITY	ST	ZIP CODE		MARRIAGE DATE ____/____/____

Section II: Change Information

A change to an election is permitted **ONLY** in the event of a change in family status, as defined by the Internal Revenue Service. The change in status must result in a gain or loss of eligibility for coverage under this plan or a spouse's plan **and** the election modification must be consistent with the change in status.

EFFECTIVE DATE OF CHANGE: ____/____/____

COVERAGE INFORMATION:

☐ Health Care Account (HCA)

HCA ELECTION AMOUNT FROM: $

HCA ELECTION AMOUNT TO: $

☐ Dependent Care Account (DCA)

DCA ELECTION AMOUNT FROM: $

DCA ELECTION AMOUNT TO: $

Section III: Termination Information

LAST DAY OF COVERAGE: ____/____/____

LAST PAY DATE: ____/____/____

Section IV: Qualifying / Life Event

Date of Qualifying / Life Event: ____/____/____

☐ Termination of employment	☐ Legal separation	☐ Divorce	☐ Childcare hours reduced (DCA only)
☐ Reduction in hours	☐ Employee deceased	☐ Marriage ____/____/____	☐ Other (must be approved): ____
☐ Employee Eligible Medicare	☐ Loss of dependent status	☐ Dependent's Date of Birth ____/____/____	

Participant Signature: ______________________________ Date Signed: ______________________________

Employer Signature: ______________________________ Date Signed: ______________________________