PLACER COUNTY OFFICE OF EDUCTATION

CHANGE IN STATUS FORM for DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Envoy Plan Services, Inc.
Corporate Office
23052-H Alicia Pkwy #605
Mission Viejo, CA 92692
Or Fax: 1-800-300-7313
Or Email: 125@EnvoyPlanServices.com

EMPLOYEE NAME	WORK PHONE NUMBER
MAILING ADDRESS	HOME PHONE NUMBER
E-MAIL ADDRESS:	CELL PHONE NUMBER

INSTRUCTIONS

- This form is applicable to the Medical Expense Flexible Spending Account (FSA) and/or Dependent Care (FSA) only. In order to amend, revoke or drop an election, please complete the section below and forward this form to the Envoy Plan Services at the address listed in the top right corner of this form.
- To amend or revoke an election under the Medical and/or Dependent Care FSA, within the same Plan Year as the election, the participant must have incurred one of the qualifying events listed below.

Medical Expense Changes

PAYROLL CHANGES

New Monthly Amount for the remainder of the current Plan Year: $________________
To be deducted over the remaining _______________ months.
First payroll date change is ____________________________.

Dependent Care Changes

PAYROLL CHANGES

New Monthly Amount for the remainder of the current Plan Year: $________________
To be deducted over the remaining _______________ months.
First payroll date change is ____________________________.

REASON FOR CHANGE

- ☐ Marriage (Date______________)
- ☐ Divorce (Date ______________)
- ☐ Disability or Leave of Absence (Date________________)
- ☐ Return from Disability or Leave of Absence (Date_____________)
- ☐ Death of Dependent (Date__________________)
- ☐ Birth of Dependent (Date___________________)
- ☐ Adoption of Dependent (Date________________)
- ☐ Change of Employment or Job Status (Date__________________)
- ☐ Spouse Employment Change (Date_________________)
- ☐ Change of Employer Benefits (Date_________________)
- ☐ Change of Day Care Needs or Availability (Date_______________)

EMPLOYEE STATEMENT – READ CAREFULLY

Please change my previously authorized election amount to the Flexible Spending Account(s) as I have indicated above. I authorize these changes to be to my pay for the remainder of the current Plan Year: I verify that I have read and understand the information on this page and that the information I have provided above is true and correct to the best of my knowledge.

_______________________________________   _______________________
Participant's Signature   Date

Envoy plan services