

Section D - Change in Status Code Chart

01	Birth or adoption of dependent	11	Employee returns to payroll (from being on a leave of absence)
02	Marriage	13	Employee changes employment status from Part-time less than 50% to Full-time
03	Divorce, legal separation or annulment *	15	Spouse or dependent terminates employment
07	Change of county of residence/worksites for employee or spouse *	17	Spouse or dependent changes employment status from Full-time to Part-time
08	Judgment, decree or court order *	20	Spouse enters leave of absence and loses FSA enrollment
10	Employee commences employment	24	Coordination of spouse's annual benefit election period

* Reviewed case-by-case

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.
- I will forfeit any unclaimed amount remaining in my account at the end of the run-out period. The run-out period ends September 30th following the last day of the plan year.
- I understand that deductions must continue during any paid leave of absence.
- I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.
- I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed, up to and including filing an order of involuntary withholding through the Office of the Comptroller.
- I understand that due to the IRS Grace Period, I can submit claims and use my EZ REIMBURSE® MasterCard® for eligible services incurred from the end of the plan year through September 15th and that those charges will be deducted from the prior plan year's account balance, if any. Expenses incurred during the Grace Period that exceed the previous year's account balance, as well as expenses incurred after September 15th, will be reimbursed out of that plan year's account, if enrolled.
- If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.

Employee Signature: _____ Date ____ / ____ / ____

Please return the signed, completed form to your agency Group Insurance Representative.

Section F – Agency Approval (To be completed by Group Insurance Representative)

Effective Date: ____ / ____ / ____ Deduction Start Date: ____ / ____ / ____

If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction: ____ / ____ / ____

Organizational Processing Code: _____ Pay Code: _____

GIR Signature: _____ Date: ____ / ____ / ____

Telephone () _____ - _____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefits Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date. If enrollment is for a university employee **paid over 9 months**, enter the End Date of the last expected deduction.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.