STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS FAMILY STATUS CHANGE APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

HOME ADDRESS	City	STATE	ZIP CODE

DEPARTMENT NAME	DEPT ID/BUDGET CODE	WORK PHONE	EDISON ID

CHANGE REQUESTED

MEDICAL EXPENSE ACCOUNT	LIMITED PURPOSE ACCOUNT	DEPENDENT CARE ACCOUNT
❑ Terminate contributions	❑ Terminate contributions	❑ Terminate contributions
❑ Start account: I wish to contribute ___________ annually, to be taken from each of my remaining regular paychecks	❑ Start account: I wish to contribute ___________ annually, to be taken from each of my remaining regular paychecks	❑ Start account: I wish to contribute ___________ annually, to be taken from each of my remaining regular paychecks
❑ Change existing account: I wish to change from ___________ per year to ___________ per year to be taken from each of my regular paychecks	❑ Change existing account: I wish to change from ___________ per year to ___________ per year to be taken from each of my regular paychecks	❑ Change existing account: I wish to change from ___________ per year to ___________ per year to be taken from each of my regular paychecks

TYPE OF FAMILY CHANGE INCURRED

REASON	DOCUMENTATION REQUIRED
❑ Marriage	Copy of marriage certificate
❑ Adoption / placement for adoption	Copy of adoption documents
❑ New employment	Letter, on company letterhead, from employer certifying hire date
❑ Return from unpaid leave	Letter, on company letterhead, from employer certifying date of return from unpaid leave
❑ Entitlement to Medicare, Medicaid or TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
❑ Birth	Copy of birth certificate
❑ Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge
❑ Court decree or order	Copy of court decree or order signed by judge
❑ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
❑ Death (employee, spouse or dependent)	Death certificate — not necessary if shows in Edison
❑ From full-time to part-time employment or vice versa (employee, spouse or dependent)	For employee, letter, on company letterhead, from spouse employer certifying change in status

Any participant changing a reimbursement account election should be sure to mark the new annual contribution to that reimbursement account. The plan will determine how much to deduct from each remaining paycheck based on the amount already contributed for the year and the number of pay periods remaining. No participant will be permitted to elect an annual contribution amount which is less than the amount already contributed during the year. When the change application along with the proper documentation is received, the approved request will be effective the following pay period. You have **60 days** from the date of the event to submit proper documentation. No retroactive change will be allowed.

See page 2 to complete the authorization and sign this form.

AUTHORIZATION

This is to certify that on ________________ (date of event), I incurred the family status change(s) checked above and, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the family status change event.

FSA and L-FSA debit card holders are required to provide proof that expenses paid for with the debit card are covered expenses permitted by the FSA program. This is called "substantiation." The State's authorized contractor may send requests for substantiation to plan members. The State cannot support the FSA program if employees fail to substantiate purchases on that card. Therefore, FSA and L-FSA debit card holders must consent to the State making deductions from their wages to repay expenses that cardholders fail to substantiate. Signature of this form is voluntary and no employee will be subject to employment based sanctions or termination from the FSA program for failure to sign. However, if a member refuses to sign it, the member will not be allowed to enroll in the FSA or L-FSA. All members who enroll in the FSA or L-FSA will receive a debit card but are not required to use it; participants may pay for qualified expenses out of pocket and file a claim with the State's authorized contractor for reimbursement.

I hereby agree that the State may deduct from my pay the amount of expenses that remain unsubstantiated thirty (30) days after the plan runout period and that authorization of payroll deduction is a condition for participating in a FSA or L-FSA. The State will provide notice of such deductions 14 days before the date of payment of your wages as required by TCA 50-2-110.

EMPLOYEE SIGNATURE	DATE