FSA CHANGE IN FAMILY STATUS FORM

COMPLETE THIS FORM ONLY TO REQUEST A CHANGE IN PARTICIPATION DURING THE YEAR.
YOU MUST SUBMIT DOCUMENTATION VERIFYING ALL CHANGES LISTED BELOW.

Complete the FSA Enrollment Form to indicate the change you wish to make in your total annual reduction Amounts or in your participation. (Changes you may make include, but are not limited to, increasing or decreasing the reduction amounts for medical/dental and/or dependent care accounts or withdrawing from FSA participation. Changes must be consistent with your change in family status. If you are decreasing your reduction, you cannot reduce the amount to less than the amount that is already in your account.) The new amounts should be the total you want deducted for the year, including any amounts previously deducted.

Check the appropriate box to indicate a change in family status. One or more of the changes listed below qualifies you to change your total annual reductions or your participation in FSA during the plan year. You must notify Deseret Mutual within 60 days of the change.

- **Change in marital status** . . . . . ❑ Marriage
  ❑ Divorce
  ❑ Legal separation
- **Change in dependent status** . . . . . ❑ Birth
  ❑ Adoption
  ❑ Death
  ❑ Loss of dependent exemption
- **Change in work status**

	You	Your Spouse
Termination or commencement of spouse's employment		❑
Part time to full time	❑	❑
Full time to part time	❑	❑
Becoming eligible for FSA	❑	❑
Other_____	❑	❑

(Attach a letter from your employer to verify changes in work status.)

- **Other changes in family status:** _____

_____

Please provide the appropriate documentation for any of the changes in family status that you have checked above. The family status and FSA participation changes will be reviewed by your employer. If your change in FSA participation is denied, you will have 60 days to appeal the decision.

I HEREBY CHOOSE THE FSA PARTICIPATION CHANGE(S) NOTED ON THE FSA ENROLLMENT FORM BECAUSE OF THE CHANGE IN FAMILY STATUS INDICATED ABOVE.

Name (printed): _____ Deseret Mutual ID: _____

Signature: _____ Date: _____

Original: Deseret Mutual; Copy: Employer; Copy: Participant