



PA State System of Higher Education | Benefits, Hughes Hall | 2986 North Second Street | Harrisburg, PA 17110-1201 | www.passhe.edu

STATUS CHANGE FORM						
MEDICAL and DEPENDENT CARE REIMBURSEMENT ACCOUNTS						
NAME (Last, First, MI)		SOCIAL SECURITY/EMPLOYEE ID#		UNIVERSITY		
MEDICAL ACCOUNT						
<input type="checkbox"/> Change <input type="checkbox"/> Stop <input type="checkbox"/> Enrollment	Current Biweekly Deduction \$	New Biweekly Deduction (Annual Deduction ÷ No. of Pay Periods) \$	Effective Date of Change			
DEPENDENT ACCOUNT						
<input type="checkbox"/> Change <input type="checkbox"/> Stop <input type="checkbox"/> Enrollment	Current Biweekly Deduction \$	New Biweekly Deduction (Annual Deduction ÷ No. of Pay Periods) \$	Effective Date of Change			
Change in Status Code	Dependent's Name			Date Status Change Occurred		
				Month	Day	Year
<input type="checkbox"/> Birth or Adoption of Child						
<input type="checkbox"/> Placement for Adoption						
<input type="checkbox"/> Gain Custody of Dependent						
<input type="checkbox"/> Lose Custody of Dependent						
<input type="checkbox"/> Child Becomes 13 Years Old						
<input type="checkbox"/> Death of Dependent						
<input type="checkbox"/> Marriage						
<input type="checkbox"/> Annulment						
<input type="checkbox"/> Legal Separation						
<input type="checkbox"/> Divorce						
<input type="checkbox"/> Death of Spouse						
<input type="checkbox"/> Change in Residence of Self, Spouse, or Dependent that affects eligibility for coverage						
<input type="checkbox"/> Change in Employment Status of Self, Spouse, or Dependent (includes start or end of employment, strike or lockout, beginning or end of a leave without pay, and change in worksite)						
<input type="checkbox"/> Change in Provider						
<input type="checkbox"/> Significant Increase in Cost of Family Care (provider cannot be a relative)						
<input type="checkbox"/> Increase or Decrease in Hours of Family Care						
<input type="checkbox"/> Dependent Receiving Care is No Longer Eligible						

I authorize the State System of Higher Education to reduce my gross biweekly pay by the new biweekly deduction specified above.

I understand that according to Federal Regulation, any money remaining in the account after all timely claims for the year have been submitted must be forfeited.

I certify that the information provided on this form is true and complete and that the election is consistent with the plan document. I understand that any misstatement or falsification of material facts will result in my removal from the Dependent Care and/or Medical Reimbursement Account Programs and may further cause an IRS and/or State audit with possible additional tax, interest, and penalties.

Employee Signature	Date	Benefits Counselor Name	Clock Number
--------------------	------	-------------------------	--------------