FBMC

proven benefit solutions

P.O. Box 1878, Tallahassee, FL 32302-1878

Date: _____ Employee SS# _____

Name: _____

Street Address: _____

City: _____ State:_____ Zip Code: _____

Enclosed you will find the necessary forms which will allow you to make a change in your Fringe Benefits Management Company plan benefits. Please complete, sign and date this form and return it in the envelope provided along with the information highlighted. Please also indicate the benefits you wish to continue; whatever you do not check will be dropped automatically.

The requested change(s) will be effective the first of the month following receipt of all properly completed documentation. BEFORE YOU SEND IN YOUR PAPERWORK, MAKE SURE THAT YOU HAVE THIS FORM SIGNED AND DATED AND A COMPLETED FRINGE BENEFITS MANAGEMENT COMPANY ENROLLMENT FORM OR YOUR CHANGE CANNOT BE APPROVED.

1. A letter from your spouse or dependent's employer stating the date he/she was hired, effective date of insurance coverage, and dependent(s) covered (if applicable).
2. A letter from your spouse or dependent's employer stating the change in insurance coverage, effective date of that change and dependent(s) covered (if applicable).
3. A letter from your spouse or dependent's employer stating the he/she terminated or retired from employment, loss of coverage (medical, dental, vision, etc), and dependents that were covered.
4. A letter from your spouse or dependent's insurance company indicating the change insurance coverage, the effective date of that change and dependent(s) covered (if applicable)
5. A copy of your marriage certificate or dependent's marriage certificate.
6. A copy of your final divorce decree or a copy of the legal separation.
7. A copy of your spouse or dependent death certificate.
8. Copies of your dependent's birth certificate.
9. A letter from your personnel stating the date you or your spouse went on unpaid leave or returned from unpaid leave.
10. A copy of your spouse or dependent's Medicare/Medicaid card.
11. A letter from dependent's college indicating graduation.
12. A letter from your dependent's college stating, full, part-time or no enrollment.
13. A copy of ineligible dependent(s) birth certificate, driver's license or enlistment forms.
14. A copy of your dependent's adoption papers or legal custody papers.
15. A notarized statement indicating your non-dependent relative is now your dependent(s) daycare provider.
16. A statement from your dependent's daycare provider showing why the daycare can no longer be offered to your dependents(s).
17. Documentation showing exactly what the Change in Status is along with the date of that change.
18. A legal documentation showing the dissolvent or closing of family owned business.

If you should have any questions, please do not hesitate to call us at 1-800-342-8017.

Sincerely,

Customer Service
Fringe Benefits Management Company

_____, incurred a Change in Status as defined by the IRS rules and therefore wish to change my FBMC plan benefits as indicated on the enrollment form enclosed.

X_____ X _____

Signature Date

State of West Virginia

MOUNTAINEER FLEXIBLE BENEFITS

CHANGE IN STATUS FORM

Social Security #			Dept./Agency		
Last Name (Please Print)		First Name			MI
Home Address	Street		City	State	Zip
Work Phone ( )	Home Phone ( )		E-mail		

Please indicate the type of Change in Status incurred:

_____ Marriage
_____ Divorce
_____ Death (employee, spouse, or dependent)
_____ Birth of child
_____ Adoption of child
_____ Beginning or end of employment of spouse
_____ Ineligibility of dependent (due to age, marriage or loss of full-time student status)
_____ From full-time to part-time employment or vice versa (employee or spouse)
_____ Unpaid leave of absence (employee or spouse)
_____ Significant change in health coverage due to spouse's employment
_____ Military Leave

This is to certify that on _____ (date of event), I incurred the Change In Status checked above, and therefore wish to change my plan benefits as indicated below. I understand that the change requested must be consistent with the change status event and I have attached legal document of such change.† **The change must be requested within 60 days of the change status event. DOCUMENTATION MUST BE INCLUDED TO PROCESS THIS CHANGE!**

Signature _____ Date _____

†*Examples of documentation include marriage, birth, or death certificate; divorce decrees; notices of legal separation; proof of change in spouse's employment; or adoption papers.*

CHANGE REQUESTED

VISION CARE*

Choose coverage:
- ☐ Employee only
- ☐ Employee & Family
- ☐ No coverage

Choose plan:
- ☐ Exam Plus
- ☐ Full Service

DENTAL CARE*

Choose coverage:
- ☐ Employee only
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Employee & Family
- ☐ No coverage

Choose plan:
- ☐ Basic
- ☐ Dental Assistance
- ☐ Enhanced

DISABILITY INCOME PROTECTION

- ☐ Employee only
- ☐ No coverage

If you choose this benefit, you must include birthdate below.

Month		Day		Year	

MEDICAL EXPENSE ACCOUNT

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____ *per paycheck* during the remainder of this plan year, to be taken from each of my remaining regular paychecks.

☐ **Change Existing Account:** I wish to change from $ _____ per paycheck to $ _____ per paycheck amount, to be taken from each of my remaining regular paychecks.

DEPENDENT CARE ACCOUNT

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____ *per paycheck* during the remainder of this plan year, to be taken from each of my remaining regular paychecks.

☐ **Change Existing Account:** I wish to change from $ _____ per paycheck to $ _____ per paycheck amount, to be taken from each of my remaining regular paychecks.

☐ I elect to receive the EZ REIMBURSE® Mastercard® Card. If you choose the card, you will be assessed a $20 per-plan-year annual fee.

* DEPENDENT INFORMATION

If you selected any coverage level followed by this symbol "*," you must complete dependent information below. Use an additional piece of paper if necessary.

LAST NAME	FIRST NAME	RELATIONSHIP	DATE OF BIRTH			SEX	CHECK COVERAGE SELECTED	
			MONTH	DAY	YEAR		DENTAL	VISION
		SPOUSE						

Mail completed form to:
Fringe Benefits Management Company
P.O. Box 1878
Tallahassee, Florida 32303-1878
Customer Service
1-800-342-8017

To be completed by **Fringe Benefits Management Company:**

Date received: _____ **Date confirmation sent:** _____
Date copy sent to state agency: _____
Payroll check effective date: _____
Benefit effective date: _____
Number of remaining paychecks: _____
New Amount: _____
Authorized by: _____