SISC Flex - Change Form

EMPLOYER:	

Employee Information (Please print clearly)

NAME:	First	MI	Last		**SS#:**	
ADDRESS:	Street Address or P.O. Box	City	State	Zip	**PHONE:**	

Indicate employee name, social security number, item(s) to be changed, sign the form and submit to your employer.

Type of change requested:

☐ Increase in monthly deduction amount (indicate new amount below) ☐ Change of address ☐ Enrollment form correction (dependents only)
☐ Decrease in monthly deduction amount (indicate new amount below) ☐ Termination from the plan (Must be a qualifying event within IRS guidelines.)
☐ Name change (If you are enrolled in the Health Care Expense Account, would you like new SISC Flex debit cards issued? If yes; check box ☐)

This change is due to the qualifying event noted below:

☐ Change in legal marital status, including marriage, divorce, death of spouse, legal separation, or annulment.
☐ Change in number of dependents under Code Section 152, including birth, adoption, placement for adoption, or death.
☐ Change in the employment status of the participant, including (a) termination or commencement of employment, (b) commencement of or return from an unpaid leave of absence, (c) change in employment status that results in the participant, spouse, or dependent child becoming or ceasing to be eligible under the individual's plan (such as switching from part-time to full-time [or from full-time to part-time] employment status.)
☐ Dependent child satisfies or ceases to satisfy dependent eligibility requirements, e.g., attainment of age, student status or any similar circumstances as provided under the Health Benefit plan.
☐ A change in dependent care provider or rates.

DATE OF QUALIFYING EVENT:_____ (Change cannot be processed without date of qualifying event.)

Please Note: A qualifying event must have occurred and the requested change must be consistent with that event.
You may call the SISC office at 661-636-4416 if you have any questions about this.

Work Phone	**Hrs worked per week**	**Date of Hire**	**Employment Status:**
			☐ Full-Time ☐ Part-Time ☐ On Leave ☐ Other: _____

Benefit Elections and Salary Reduction Authorization
Expense Account Elections: I request the following amounts be deducted from my pay with pretax dollars:

	Number of Pay Periods remaining		**$ Per Pay Period remaining**
Health Care Expense Account **$2,550.00 maximum (2016 plan year)**	_____	=	$_____
Dependent Care Expense Account **$5,000.00 maximum per year** (per family)	_____	=	$_____

Spouse/Dependent Information

Spouse and Dependent's First, MI and Last Name	**Relationship**	**Social Security No.**	**Date of Birth**

Use additional page, if needed, to list more dependents.

The following information is required for enrollment in the Dependent Care Expense Account only:
Marital status of participant (employee) _____ Spouse's wages _____
If not employed, is spouse incapacitated or a full-time student? _____
Are these services necessary to enable the participant to be gainfully employed? _____

Agreement: *I have received, read and understand the SISC Flex employee brochure and the SISC Flex debit Visa card questions and answers document. For expense accounts, the amount(s) I have elected will be taken from my pay in equal installments. I understand that if I fail to submit eligible claims for the total amount elected, I forfeit any remaining balance. The election(s) will continue throughout the plan year or until I submit a change form indicating a qualifying status change. For Dependent Care Expense Account claims, I understand that I must submit the caregiver's tax identification number with each claim. Under penalty of perjury I certify that this amount does not exceed any IRS guidelines for annual limits. I understand the change in election will be effective the 1st day of the month following the month in which the election change form is received and approved by SISC Flex. An election change for the Health Care Expense Account due to birth, adoption or placement for adoption will be effective retroactive to the date of birth, adoption or placement for adoption, provided you request a change in your annual election within 30 days of the birth, adoption or placement for adoption. Election changes for other special enrollment events (e.g., marriage or loss of other health coverage) will be effective as soon as practicable once your request for such election change has been received and approved, provided your request is made within 60 days of the event.*

Employee Signature_____ **Date:** _____

Return the completed form to your employer.

Employer's use only:
Effective date of change: _____ First payroll deduction date: _____

Received and approved by authorized employer administrator: _____ Date: _____

If employee is retiring, please indicate the applicable retiree SISC Health Benefits plan. Anthem Blue Cross ☐ Blue Shield ☐ Kaiser ☐ CalifCare ☐ **N/A** ☐

(This change form must be received, processed, and approved by the SISC Flex office before the change becomes effective.) **7-2015**