RESET

Horizon Blue Cross Blue Shield of New Jersey

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You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Unreimbursed Medical / Dependent Care Spending Account Change in Family Status While Actively Employed

Employee Name: _____ _____ _____ ID#: _____
Last First MI

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone Number: _____ – _____ – _____ Work Phone Number: _____ – _____ – _____

EMPLOYER NAME: _____

*You **MUST** complete this form and return it to your benefits administrator within sixty (60) days of the change in family status in order to elect to participate or change your annual election amount.*

Date of Change in Family Status: _____ / _____ / _____
MM DD YYYY

Please check one of the following:

- ☐ New Election
- ☐ Change my Annual Salary Deduction Amount
- ☐ Suspend my Annual Salary Deduction Amount

Due to:

- ☐ Marriage
- ☐ Divorce
- ☐ Birth or legal adoption of a child
- ☐ Death of a dependent
- ☐ Change in work status of spouse
- ☐ Significant change in health coverage due to spouse's employment
- ☐ Change in cost or coverage of Dependent Care

New Election due to Change in Family Status

☐ I elect to participate in the Unreimbursed Medical Spending Account. I direct and authorize my employer to reduce my annual salary for the remainder of the calendar year by $_____ . I understand that my salary will be reduced in e**qual amounts** from my regular paycheck.

☐ I elect to participate in the Dependent Care Spending Account. I direct and authorize my employer to reduce my annual salary for the remainder of the calendar year by $_____ *(max.$5,000)*. I understand that my salary will be reduced in **equal amounts** from my regular paycheck.

Change: Please complete the following:

☐ I elect to change my Annual Salary Deduction Amount from $_____ to $_____ for the Unreimbursed Medical Spending Account due to a Change in Family Status.

☐ I elect to change my Annual Salary Deduction Amount from $_____ to $_____ for the Dependent Care Spending Account due to a Change in Family Status.

I understand that:

This election will remain in effect and cannot be revoked and changed during the Calendar Year, unless the revocation and new election are on account of and consistent with the occurrence of a Change in Family Status.

Employee Signature: _____ *Date:* _____ / _____ / _____
MM DD YYYY

FOR EMPLOYER USE ONLY

BENEFITS ADMINISTRATOR: _____ DATE: _____ / _____ / _____
MM DD YYYY