

**DEPENDENT CARE REIMBURSEMENT ACCOUNT  
REQUEST FOR CHANGE IN STATUS FORM**

COMPANY NAME \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_ SS# \_\_\_\_\_

When you have a qualifying change in status, you may request a change to revoke the existing plan election and make a new election for the remainder of the current plan year. Election changes are generally restricted to *events that affect eligibility*, or those that affect the *cost or coverage* of care. To be permitted, a qualifying event must occur, and the election change must be "consistent" with the event (Section 2 explains "consistent").

Complete Sections 1, 2 and 3 and submit to Benefits within 31 days of the change in your status. Your request will be reviewed and a determination made as to whether the request is permissible under current regulations.

**SECTION 1** (NOTE: You may be required to submit appropriate documentation to verify the event.)

Check one of the following qualifying change in status events that you have experienced:

- Marriage or Divorce
- Death of a spouse or dependent child
- Birth or adoption of a child
- Change from part-time to full-time employment, or from full-time or part-time employment by your or your spouse
- Commencement or termination of your spouse's employment
- Taking unpaid leave of absence by your or your spouse
- Dependent child enrolled in school
- Change in dependent care coverage
- Change in cost of dependent care, except when a relative provides the service

Date of Change in Status event identified above: \_\_\_\_\_ New Annual Election Amount: \$ \_\_\_\_\_  
Your per pay period deduction will be calculated below by your Employer.

**SECTION 2**

Please explain below the election change you wish to make. Also explain why your requested change is consistent with your status change. An election change is consistent only if the election change is necessary or appropriate as a result of the status change event.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3**

I have read and fully understand the regulations to change my election. I understand that this Change in Status Form must be completed within 31 days of the change in status event, and the election change I have requested must be consistent with the change in status event. I understand any election change will be effective on the later date of either the change in status or the date I requested the election change. I certify that the above information is true and correct, and agree to provide any necessary third-party documentation to verify the change in status event.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**TO BE COMPLETED BY EMPLOYER:** Calculate the per pay period deduction based on employee information.  
DEPENDENT CARE REIMBURSEMENT ACCOUNT

New DCRA annual election	-	YTD contribution	=	Remaining DCRA annual election to be deducted from paycheck	)	# Pay periods remaining	= \$	Paycheck deduction
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Effective date the above election change will be in effect \_\_\_\_\_ (date of paycheck)

EMPLOYER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE RETURN TO: Benefits  
6054 S. Drexel, 2<sup>nd</sup> Floor  
Chicago, IL 60637