

St. Cloud Area School District 742

Status Change Form

10/1/09 – 9/30/10

EMPLOYER SECTION: To be completed by employer.

Employee Name (please print)	Social Security #
------------------------------	-------------------

The employee may change salary reduction and allocation of benefits during the plan year only if they experience a CHANGE IN FAMILY STATUS. If sometime during the year you are: (Check the appropriate change)

Date of Change _____	Contributions change on payroll date _____
<input type="checkbox"/> Married	<input type="checkbox"/> A child is born or adopted
<input type="checkbox"/> Divorced	<input type="checkbox"/> A dependent child reaches the coverage limit of the plan
<input type="checkbox"/> Spouse commenced or terminated employment	<input type="checkbox"/> Change in full-time or part-time employment for employee
<input type="checkbox"/> Death of a dependent	<input type="checkbox"/> Change in full-time or part-time employment for spouse
<input type="checkbox"/> Unpaid leave of absence by employee	<input type="checkbox"/> Return to work following leave of absence for employee
<input type="checkbox"/> Unpaid leave of absence by spouse	<input type="checkbox"/> Return to work following leave of absence for spouse
<input type="checkbox"/> Return to full-time student	<input type="checkbox"/> No longer a full-time student
<input type="checkbox"/> Other _____	

NOTE: For protection, written proof of the change in status should be required of the employee. Notify payroll of new salary reduction amount.

EMPLOYEE SECTION: To be completed by employee.

New Contribution

↓INDICATE CHANGES ONLY↓	Per Pay	Plan Year Amount
Flexible Spending Account <input type="checkbox"/> I choose to participate (Maximum \$10,000 for the plan year) <input type="checkbox"/> I choose not to participate	\$ _____	\$ _____
Dependent Care Account <input type="checkbox"/> I choose to participate (Maximum \$5,000.00 for the plan year/\$416.66 per mo.) <input type="checkbox"/> I choose not to participate	\$ _____	\$ _____
Flexible Spending Account and Dependent Care Account Reimbursement:		
Direct deposit required (please complete a Credit Authorization Form)		
For Additional Debit Card(s) for a qualifying spouse, call SOMI customer service at (651) 695-2555 or 1-888-330-8408		

SIGNATURE (REQUIRED)

I hereby certify that the information I have provided is true and correct, and I authorize any insurance company, plan administrator, or educational institution to release any information regarding other insurance coverage or student status regarding me or my covered dependents to Sheffield, Olson & McQueen, for the purpose of benefit coordination.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION ON THIS FORM MAY RESULT IN THE DENIAL OF CLAIM(S) AND/OR TERMINATION OF COVERAGE.

Employee Name (print) _____ Social Security _____

Employee Signature _____ Date _____

SOMI USE ONLY

Rims:	Flex:	Rx:	Notice:	Other:
-------	-------	-----	---------	--------