

TAI**Flexible Benefit Plan - Modification Form****ONLINE***All Information Required - Print Clearly - Sign & Date Below*▶ **EMPLOYER** _____

Employee _____ Social Security # _____

Home Address (Street) _____ Check box if: New Address

City _____ State _____ Zip code _____

Daytime Phone () _____

E-Mail Address _____

Status Changes for Modifying Flex-Plan Reimbursement Accounts

I may modify my accounts when there has been a change in my family status which means: marriage; annulment; legal separation; divorce; custody; birth or adoption of a child or addition/deletion of any dependent; the switching from full-time to part-time employment or vice versa by me or my spouse; or termination of spouse's employment or commencement of spouse's employment. I may also change my benefit accounts if either myself or my spouse takes an unpaid leave of absence or if there is a significant change in my medical benefits or premiums or those of my spouse due to plan design or Medicaid or Medicare; or a HIPAA election. I may modify my dependent care account if I switch providers, change my residence or worksite. **I am obligated to notify my Employer within 30 days of the events described above to modify my reimbursement accounts. Explain below your reason(s) for modification:**

Health Care Reimbursement Account

Annual Amount - Original	Pay Period Deduction	New Annual Amount	New Pay Period Deduction
\$	\$	\$	\$

Dependent Care Reimbursement Account

Annual Amount - Original	Pay Period Deduction	New Annual Amount	New Pay Period Deduction
\$	\$	\$	\$

*Completed by Employer*Payroll Effective Date: _____
[Start of New Deductions]Approved by H.R. Dept.: _____
[Signature or Initials]

▶ Employee Signature _____ Date _____

Routing: Original to Employer's H.R. Dept. • Copies for Participant and TAI

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