Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) Employee Status Change Form

Employer name: ______________________________

Employee name: ______________________________ Soc. Sec. No.: ______________

☐ **Change in employee information**

Name change to: ______________________________

Home address: Number/street: ______________________________

City: ______________________ State: __________ Zip: ______________

Phone number: ______________________________

☐ **Termination of employee's employment**

Date of termination: _____/_____/_____ Year to date deduction amount: $____________

☐ Check here to have Infinisource offer COBRA continuation of coverage for Health FSA or HRA (only if Employer has contracted with Infinisource to also administer COBRA)

☐ **Reinstatement due to Election of COBRA coverage for the Health FSA or HRA**

Amount of Health FSA Monthly Premium (annual election ÷ 12): $________ Paid to date:____/____/____
Amount of HRA Monthly Premium (must be actuarially determined): $________

☐ **Leave of absence and/or layoff**

Date of leave/layoff: _____/_____/_____ Date of anticipated return: _____/_____/______

Date of last payroll deduction: _____/_____/_____ Does this leave qualify under FMLA? ☐ Yes ☐ No

If FMLA, is employee revoking coverage? ☐ Yes ☐ No (If yes, Infinisource will enter a termination date)

If continuing coverage, which payment options have been chosen?
☐ Pre-pay (pre-tax)
☐ Pay as you go (after tax)
☐ Catch up (pre-tax)

Employer Representative Signature: ______________________________ Date: ______________

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