

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 Contribution Amount: \$ _____

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: _____