

# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last payroll deduction: \_\_\_\_/\_\_\_\_/\_\_\_\_

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: \_\_\_\_\_