



**State of Wisconsin – Department of Employee Trust Funds  
Employee Reimbursement Accounts Program  
CHANGE IN STATUS FORM**

Social Security #		Employer (Please indicate the State Agency & Division or UW Campus)		
Last Name (Please Print)		First Name		MI
Home Address Street		City	State	Zip
Work Phone ( )	Home Phone ( )	E-mail		

**QUALIFIED CHANGE EVENTS: (CHECK AND DATE ALL THAT APPLY)**

<p><b>DATE</b></p> <p><input type="checkbox"/> _____ Marriage</p> <p><input type="checkbox"/> _____ Death : <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent</p> <p><input type="checkbox"/> _____ Birth of child</p> <p><input type="checkbox"/> _____ Ineligibility of dependent (due to age, marriage or loss of full-time student status)</p> <p><input type="checkbox"/> _____ Spouse Employment: <input type="checkbox"/> Begins or <input type="checkbox"/> Ends</p> <p><input type="checkbox"/> _____ Change from full-time to part-time employment (or vice versa) for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent</p>	<p><b>DATE</b></p> <p><input type="checkbox"/> _____ Divorce</p> <p><input type="checkbox"/> _____ Legal Separation</p> <p><input type="checkbox"/> _____ Adoption (or placement for adoption) of child</p> <p><input type="checkbox"/> _____ Change in Dependent Care provider</p> <p><input type="checkbox"/> _____ Spouse's unpaid leave: <input type="checkbox"/> Begins or <input type="checkbox"/> Ends</p> <p><input type="checkbox"/> _____ Employee's unpaid leave <input type="checkbox"/> Begins or <input type="checkbox"/> Ends</p> <p><input type="checkbox"/> _____ Other _____</p>
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**TYPE OF CHANGE REQUESTED**

<b>Change Existing Account</b>	<b>Start Account</b>	<b>Terminate Account</b> (Future Medical Expense services will <b>not</b> be reimbursable.)
<input type="checkbox"/> Medical Expense Account <input type="checkbox"/> Dependent Care Account	<input type="checkbox"/> Medical Expense Account <input type="checkbox"/> Dependent Care Account	<input type="checkbox"/> Medical Expense Account <input type="checkbox"/> Dependent Care Account

**CALCULATE YOUR NEW PER PAYCHECK DEDUCTIONS**

	<b>MEDICAL EXPENSE ACCOUNT</b> [Maximum allowable contribution is \$7,500 per employee; Minimum is \$100.]	<b>DEPENDENT CARE ACCOUNT</b> [Refer to Tax Filing Status for Maximum allowable contribution] →	<b>TAX FILING STATUS</b> [PLEASE CHECK ONE]:
A. Current Total Annual Contribution (if applicable)			<input type="checkbox"/> Married, filing separately [maximum—\$2,500]  <input type="checkbox"/> Married, filing jointly [maximum—\$5,000]  <input type="checkbox"/> Single, head of household [maximum—\$5,000]
B. New Total Annual Contribution			
C. Amount Contributed Thus Far (if applicable)			
D. Amount Needed to Meet New Annual Goal (B. minus C.)			
E. # of Paychecks from which deductions to be taken*			
F. New Per Paycheck Deduction Amount (D. divided by E.)			
* Consult your Payroll Office for payroll information			

**Comments:**

I certify that on the date(s) indicated, I incurred the Change in Status\* event(s) checked above and therefore wish to change my plan elections as indicated. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my period of coverage. **The change in election will be effective on the first day of the month on or following the date a valid CIS form is received by FBMC's Madison Office. Expenses incurred before my effective date will not be reimbursed.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY FBMC'S MADISON, WISCONSIN OFFICE:**

Date Received by FBMC/Madison: _____	New Amount(s): <input type="checkbox"/> Med. Expense _____ <input type="checkbox"/> Dependent Care _____
Date Copy Sent to State Agency/Campus: _____	Remaining No. of Deductions for Med. Expense: _____ Dependent Care: _____
Agency Code: _____	Date Sent to FBMC/FL: _____ Authorized by: _____
Payroll Check Effective Date: _____	Effective Date of Change(s)/Coverage: _____

**SEE BACK FOR FURTHER DETAILS**

## CHANGES DURING THE YEAR

You may change your ERA election mid-plan year only when a qualified Change in Status event has occurred. Experiencing one of the CIS events listed does not automatically permit a mid-plan year election change. To be eligible, status changes must comply with the IRS general consistency requirement as stated below. A mid-plan year election change can only be made on a future basis.

### TO REQUEST AN ELECTION CHANGE:

1. Review the Change in Status section of your ERA Enrollment booklet to determine if you have a valid Change in Status. If you have any questions about the eligibility of a requested change or completing the form, contact FBMC's Madison office or call the toll-free FBMC Customer Service number listed below. Check with your payroll representative for the number of paychecks remaining in the plan year.
2. Complete, sign and date the form and mail or fax copies to FBMC's Madison office for authorization and processing. The form must be signed and dated within **30 days** of the event.
3. Please retain a copy of documentation supporting your mid-plan year election change request. (It does not need to be submitted with your request.) Examples of documentation are marriage licenses, divorce decrees, birth certificates, etc.
4. FBMC's Madison office will review, on a uniform and consistent basis, the facts and circumstances of each properly completed and timely Change In Status Request form.
5. If the requested change is authorized, a copy of the form will be forwarded to your payroll office and to FBMC's Florida headquarters to be processed.
6. The effective date of any change(s) will be the first day of the month on or following the date a valid CIS form is received by FBMC's Madison Office.
7. If your ERA election change request is denied, you will have 30 days from the date of the denial to file an appeal with FBMC by following the procedures in the "Appeals Process" section appearing in your ERA enrollment booklet.

### CHANGE IN STATUS EVENTS: (See your ERA enrollment booklet for more detailed information about Change in Status Events.)

- Change In Your Legal Marital Status  
Marriage, death of spouse, divorce, legal separation, and annulment.
- Change In Number of Your Tax Dependents  
Birth, death, adoption, and placement for adoption.
- Changes In Employment Status That Affect Eligibility  
Change in the employment status of the employee, the employee's spouse, or the employee's dependent; termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; and change in worksite.
- Dependent satisfies or ceases to satisfy eligibility requirements.  
Dependent satisfies or ceases to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- Change in Place of Residence (Your Own, Your Spouse or Dependent). (Dependent Care Accounts Only)
- Changes in Cost or Coverage (Dependent Care Accounts Only)  
Cost increases or decreases, significant service curtailment, open enrollment under spouse's plan
- Certain Judgments, Decrees, or Court Orders (Medical Expense Accounts Only)
- Eligibility for Medicare or Medicaid (Medical Expense Accounts Only)

### CONSISTENCY RULE:

- Generally, an election change satisfies the consistency requirements only if the change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. In addition, for dependent care accounts only, an election change also satisfies the consistency requirements if the election change is on account of and corresponds with a change in status that affects dependent care expenses.

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