



TERMINATION - LEAVE OF ABSENCE - STATUS CHANGE GUIDELINES & FORMS

Providing prompt and timely changes is critical to the accurate maintenance of your participants' records. Listed below are instructions on completing this Multipurpose Form - Employee Termination/Leave of Absence/Status Change Form. Please submit all such changes on the appropriate attached form(s) to flexpro@keybenefit.com for prompt review and processing.

Forms: Page 2 - Employee/Dependent Changes to Demographics (Address, email, DOB, Name)

Page 3 – Employee/ Dependent Termination Form

Page 4 - Employee Leave of Absence Form

Page 6 - Employee Status Change & Qualifying Event Form

General Information

Page 2 - Employee Demographic Changes to Demographics - Please review the appropriate for any address emails, DOB or name changes.

Page 3 - Employee Termination Form - Please review the appropriate from and fill out the required fields completely. In order to minimize employer exposure for over spending on the part of the employee, it is critical that terminations are submitted as near as possible to the time they occur. If your employer group utilizes the Flexpro Master Card Debit Card, it is our recommendation that you ask the terminating employee to turn in their card prior to leaving which will help protect your plan from any potential inappropriate use of the card. It is important that you have a Cobra process in place for all terminations. KBA offers Cobra as an added service.

Page 4 and 5 – Employee Leave of Absence Form - Please review the appropriate from and fill out the required fields completely. There are specific guidelines determining how to handle deductions for paid and unpaid leaves as well as special eligibility for those with DCA account also on a leave of absence. Please see the Guidelines section of this form for specifics. We have included both a “Begin Leave” and “Return from Leave” page that you can provide to us.

Page 6 – Employee Status Change/Qualifying Event Form - Please review the appropriate from and fill out the required fields completely. Changes to participant accounts (FSA, DCA, HRA, HSA, & IND plans) must follow specific guidelines to be considered as eligible. They must also fall within the specified time frame indicated in the employer's Adoption Agreement/SPD Specific Information Page.

Please note that an employee's benefit election for any Plan Year is irrevocable during the Plan Year, except for certain specified circumstances, as described in the plan document. A Participant may stop or prospectively increase or decrease his election under the Plan within the time frame outlined in the Adoption Agreement if specified criteria for the event being qualified has been met. Please see each form for specific instructions and refer to your employer's Plan Document for a list and description of all eligible change in status situations.

Submitting Forms

Please submit the appropriate form from those attached after it has been fully filled out according to any related guidelines and instructions. Be SURE to date and sign the form and if possible have the employee also sign and date. The completed form can be mailed, faxed or emailed it to:

Key Benefit Administrators
Attn: FlexPro
PO Box 1179
Ft. Mill, SC 29716-1179
Fax: 866-241-1488
Email: flexpro@keybenefit.com

Employee Demographics Change Dependent Demographic Change or Termination Form

* Indicates a required field, failure to supply required information may result in a delay in processing this request.

Group Name*:	Group Number :
Circle One : Employee Dependent First Name*	Circle One : Employee Dependent Last Name*:
<input type="checkbox"/> Name Change From:	
Address*: <input type="checkbox"/> Address Change	Circle One : Employee Dependent SSN*:
For Dependent changes please provide Employee SSN	Employee SSN * :
Address #2:	Employee E-Mail Address** <input type="checkbox"/> Add / Update
City*	Daytime Phone Number* <input type="checkbox"/> Add / Update
State & Zip*:	Mobile Phone Number * <input type="checkbox"/> Add / Update

For Employers with HRA's Benefit Plans Additional Dependent information is required for Dependents

Dependent Date of Birth: ___/___/_____	Dependent Gender: <input type="checkbox"/> male <input type="checkbox"/> female
Dependent Relationship to Employee:	<input type="checkbox"/> Spouse/Common Law <input type="checkbox"/> Child
NOTES FOR REQUEST CLARIFICATION	

- Dependent Termination notice Effective date of Termination from Employee's Plan ___/___/_____
- Dependent Enrollment notice Effective date of Enrollment in Employee's Plan ___/___/_____
- For Employers with HRA type benefit plans utilizing benefit funding based on Single, Single + or Family, Changes to Dependents may affect the eligibility criteria and funding options as out lined by the Plan.
 - NO - The changes listed on this form will not affect the Employee's benefit status or funding for that status.
 - YES - The changes listed on this form will affect the Employee's benefit status and funding for that status.
 - From (circle one) Single, Single + SP, Single + CH or Family
 - To (circle one) Single, Single + SP, Single + CH or Family
- For Employees with FSA type benefits please see Page 6 of this document for employee account change details
- Employee and Dependent Demographic changes alone require only the above section. Check the appropriate change(s) and sign the bottom of this page. ** When an employer group has elected to utilize mobile phone functionality employees will be able to log in to the Wealthcare Portal and register their phone numbers. This will allow participants to receive specific message via SMS texts. For example current account balances. (charges may apply depending on members individual service contracts)
- If the dependent will be using a different mailing address for receiving the Master Card Debit Card please indicate that in the notes section.
- For employers with HRA benefit plans Medicare reporting rules specify that Key Benefit- Flexpro is required to attempt to gather the above indicated information for dependents added to the HRA benefit. The required information is noted in the section above.
- If there are no other changes, print this page and email or fax it back to the contact information on the 1st page. No other pages are required to be returned.
- Employers are requested to submit all changes promptly to maintain accurate accounting of participant's status and eligibility.
- Employers are responsible to review any relevant requirements to determine Eligible Qualifying Events for changes indicated.

****Employer Representative Signature:** _____ **Date** _____

****Signature Required in order for request to be reviewed and completed by KBA FlexPro.**

Employee Only Termination Form

* Indicates a required field, failure to supply required information may result in a delay in processing this request.

Group Name*:	Group Number :
Employee First Name*: <input type="checkbox"/> Name Change	Employee Last Name*: <input type="checkbox"/> Name Change
Employee Address* <input type="checkbox"/> Address Change	Employee SSN*:
Address #2:	Employee E-Mail Address*: <input type="checkbox"/> Email Change
City*	State & Zip*:
Name Changed From:	Notes:

Please complete lines for each eligible benefit type for the above listed Employee.

The Total Reductions amount is the amount KBA will use to match your records for the final total deducted on behalf of Employees. COBRA amounts will be calculated, if requested, using this data.

	Last Day Worked: ____/____/____	Date of Final Payroll Reduction: ____/____/____
FSA	Amount of last reduction: \$	Total Reductions Effective as of Term Date **: \$
DCA	Amount of last reduction: \$	Total Reductions Effective as of Term Date **: \$
IND	Amount of last reduction: \$	Total Reductions Effective as of Term Date **: \$
HRA	Amount of last reduction: \$	Total Reductions Effective as of Term Date **: \$
HSA	Amount of last reduction: \$	Total Reductions Effective as of Term Date **: \$

**The final total of reductions taken for an employee should be only those that have occurred within the plan dates that the employee is eligible. (i.e., if the plan year is 07/01/2012 – 06/30/2013, then the final total would be the amount collected from 07/01/2012 through the term date for the entire plan year in which the participant was enrolled of last reduction.)

Termination - Please complete the last day worked and the date and amount of the last reduction. Please provide the year-to-date totals for each category. The termination date will be shown as the last day worked. These dates may or may not be the same. The incurred and submitted timeframes will be based on this termination date.

It is critical that terminations are submitted as soon as they occur so we can update the participants Flex Account (if required) adjust our system-and prevent terminated employees from being paid inappropriately. If you have the Flexpro MasterCard Debit Card, it is our recommendation that you ask the terminating employee to turn in their card prior to leaving. This will help protect your plan from any potential inappropriate use of the card. It is important that you have a Cobra process in place for all terminations. KBA offers Cobra as an added service.

Employers are requested to submit all changes promptly to maintain accurate accounting of participant’s status and eligibility.

****Employer Representative Signature:** _____ **Date** _____

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Leave of Absence Form – Begin Leave

* Indicates a required field, failure to supply required information may result in a delay in processing this request.

<u>Group Name:</u>	Group Number :
<u>Employee First Name:</u>	<u>Employee Last Name:</u>
<u>Employee Address:</u>	<u>Employee SSN:</u>
<u>Address #2:</u>	Employee E-Mail Address:
City	<u>State & Zip:</u>
Name Changed From:	Notes:

Please indicate if there are any changes as well. Employee Name Change Address Change Email Change

Leave of Absence – Begin (See explanations below)

Will employee deductions continue during (LOA) Leave Start Date: ____/____/____

YES	FlexPro will continue with eligibility and deductions as per annual enrollment.- no changes to current Flex Benefits **
NO	FlexPro will be advised upon return from LOA by the employer of any changes to above listed Employee accounts and funding. This will put the employee's account on processing restrictions based on the dates provided. (1)*

Please circle the plan and enter the requested amounts below for any applicable benefits

FSA/LPF	DCA **	IND	HRA	HSA	Amount of last reductions: \$	Total Reductions as of LOA \$
FSA/LPF	DCA **	IND	HRA	HSA	Amount of last reductions: \$	Total Reductions as of LOA \$
FSA/LPF	DCA **	IND	HRA	HSA	Amount of last reductions: \$	Total Reductions as of LOA \$
FSA/LPF	DCA **	IND	HRA	HSA	Amount of last reductions: \$	Total Reductions as of LOA \$

Employers are requested to submit all changes promptly to maintain accurate accounting of participant's status and eligibility.

Leave of Absence Guidelines

Leave of Absence - Please review requirements/qualifications related to eligibility. **Please note that an employee's benefit election for any Plan Year is irrevocable during the Plan Year, except for certain specified circumstances, as described in the plan document.** A

Participant may stop or prospectively increase or decrease his election under the Plan within the time frame outlined in the Adoption Agreement if one of the following change in status events occurs. The change must be on account of and correspond with the change in status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent. Eligible Status Change Events include (but may NOT be limited to) changes in marital status; the number of tax dependents; employment status of the employee, spouse and/or dependent; dependent satisfies (or ceases to satisfy) dependent eligibility requirements; residence change; adoption assistance. Please refer to your plan document for a list and description of all eligible change in status situations.

FSA Health Care: A Participant on an unpaid leave of absence must make a status change, pay the reductions on an after-tax basis while on leave or make up the reductions upon return from an unpaid leave of absence for the FSA Health Care. If no payments are made to cover the leave time, the participant will not be eligible to receive reimbursement for health care claims incurred during the leave.

(1) Employee's will only be eligible for claims with Dates of Service that fall within the dates the Employee is actively participating in the Flex Plan. If the Employee is continuing to have deductions taken they would be eligible for a continuation of Flex Benefits as enrolled.

FSA Dependent Care: **Dependent Care may not be reimbursed while on Leave of Absence (LOA). *Exception for short, temporary absences as defined by the IRS as no more than 2 consecutive calendar weeks.* A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the caregiving arrangement requires the taxpayer to pay for care during the absence. An absence of 2 consecutive calendar weeks is a short, temporary absence.

****Employer Representative Signature:** _____ **Date** _____

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Leave of Absence Form – Return from Leave

* Indicates a required field, failure to supply required information may result in a delay in processing this request.

Group Name:	Group Number :
Employee First Name: <input type="checkbox"/> Name Change	Employee Last Name: <input type="checkbox"/> Name Change
Employee Address: <input type="checkbox"/> Address Change	Employee SSN:
Address #2:	Employee E-Mail Address: <input type="checkbox"/> Email Change
City	State & Zip:
Name Changed From:	Notes:

Leave of Absence – Ends (See explanations below)

Will employee be making up any missed deductions during (LOA)?

YES	The employee will be making arrangements to make up missed deductions. Please see the Detailed Changes Section **
NO	The employee continued to have the same deductions as enrolled during the LOA period. NO additional changes are required at this time. Please see the Detailed Changes Section for confirmation of the Employee Annual and Per Pay.

Returned from Leave Date: ____ / ____ / ____ Reductions to resume date ____ / ____ / ____ (1)

Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay (1) \$	Lump Sum Deduction Amount \$	Total Expected Contributions \$				

Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay (1) \$	Lump Sum Deduction Amount \$	Total Expected Contributions \$				

Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay (1) \$	Lump Sum Deduction Amount \$	Total Expected Contributions \$				

Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay (1) \$	Lump Sum Deduction Amount \$	Total Expected Contributions \$				

Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay (1) \$	Lump Sum Deduction Amount \$	Total Expected Contributions \$				

Leave of Absence Guidelines

Employers are requested to submit all changes promptly to maintain accurate accounting of participant’s status and eligibility.

Leave of Absence - Please review requirements/qualifications related to eligibility. **Please note that an employee’s benefit election for any Plan Year is irrevocable during the Plan Year, except for certain specified circumstances, as described in the plan document.** A Participant may stop or prospectively increase or decrease his election under the Plan within the time frame outlined in the Adoption Agreement if one of the following change in status events occurs. The change must be on account of and correspond with the change in status that affects coverage eligibility of a Participant, a Participant’s Spouse, or a Participant’s Dependent. Eligible Status Change Events include (but may NOT be limited to) changes in marital status; the number of tax dependents; employment status of the employee, spouse and/or dependent; dependent satisfies (or ceases to satisfy) dependent eligibility requirements; residence change; adoption assistance. Please refer to your plan document for a list and description of all eligible change in status situations.

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****Employer Representative Signature:** _____ **Date** _____

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Status Change Form

* Indicates a required field, failure to supply required information may result in a delay in processing this request.

<u>Group Name:</u>	Group Number :
<u>Employee First Name:</u> . <input type="checkbox"/> Name Change	<u>Employee Last Name:</u> . <input type="checkbox"/> Name Change
<u>Employee Address:</u> <input type="checkbox"/> Address Change	<u>Employee SSN:</u>
<u>Address #2:</u>	<u>Employee E-Mail Address:</u> <input type="checkbox"/> Email Change
City	<u>State & Zip:</u>
Name Changed From:	Notes:

Common Qualifying Reasons for Change: please mark applicable selection (1) * Date of Event: ____/____/____

Change in employee's marital status
 Change in Employment Status(LOA /Term, etc)
 Judgment, decree, court order
 HIPAA Special Enrollment
 Change in # of dependents
 Change in dependent eligibility
 Death of Employee
 Other: _____

- Qualifying Events Restrictions and Explanations (2):**
- Change in Residence; Eligible for IND PREM changes. *Does NOT allow for changes to Healthcare FSA.*
 - Adoption Proceedings : Applies to an adoption assistance program. ONLY if available through your employer's cafeteria plan
 - Significant Cost Change; Eligible for IND PREM and DCA Account changes. FSA/ LPF plans are not automatically eligible for this change

The noted Qualifying Event will require the following change(s)

- New Employee Enrollments: Please see Current Renewal Documentation for the Enrollment form if applicable.
- Add or Remove Dependents/ Changes to Employee or Dependent Demographics details: Please see page 2 of this document. For changes affecting funding continue with this form
- Please see page 3 of this document for Employee Termination only

Effective date of Change ____ / ____ / ____ **(mark all applicable benefits)**

Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay \$	Previous Annual \$		<input type="checkbox"/>	Change	Annual	\$
Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay \$	Previous Annual \$		<input type="checkbox"/>	Change	Annual	\$
Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay \$	Previous Annual \$		<input type="checkbox"/>	Change	Annual	\$
Circle and provide details for the applicable benefit types as needed			FSA/LPF	DCA**	IND	HRA	HSA
Previous Per Pay \$	New Per Pay \$	Previous Annual \$		<input type="checkbox"/>	Change	Annual	\$

Status Change Guidelines

Employers are requested to submit all changes promptly to maintain accurate accounting of participant's status and eligibility.

- (1) Status change requests must coincide with IRS eligible qualifying event. Example: If you get married, you can increase but not decrease the annual election (up to the maximum allowed under your plan). If you get divorced, you can decrease not increase the annual election. Please see page 3 of this document for Employee Only Termination form.
- (2) Some life events are not deemed to be eligible as Qualifying Events according to regulations. If the information provided here does not cover the current situation please contact Flexpro as noted on page 1.

Please note that an employee's benefit election for any Plan Year is irrevocable during the Plan Year, except for certain specified circumstances, as described in the plan document.

- A Participant may stop or prospectively increase or decrease his election under the Plan within the time frame outlined in the Adoption Agreement if one of the following change in status events occurs. The change must be on account of and correspond with the change in status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent. Eligible Status Change
- Events include (but may NOT be limited to) changes in marital status; the number of tax dependents; employment status of the employee, spouse and/or dependent; dependent satisfies (or ceases to satisfy) dependent eligibility requirements; residence change; adoption assistance. Please refer to your plan document for a list and description of all eligible change in status situations.

****Employer Representative Signature:** _____ **Date** _____

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