WageWorks
formerly Planned Benefit Systems

PARTICIPANT CHANGE FORM

PLAN INFORMATION

EMPLOYER NAME _____ PLAN YEAR _____

EMPLOYEE INFORMATION

Please provide information as it currently appears on your account. SOCIAL SECURITY NUMBER _____

FIRST NAME _____ LAST NAME _____

NAME CHANGE

FIRST NAME _____ LAST NAME _____

ADDRESS/PHONE/EMAIL CHANGE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DAYTIME PHONE _____ E-MAIL[1] _____

[1] **Email:** By providing your email address, you agree to receive Employee Benefit Plan correspondence electronically. WageWorks does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, help@pbs.us.com, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the WageWorks Customer Service Department or by visiting our website at www.pbs.us.com. WageWorks reserves the right to utilize an email address that may be provided to us by your employer.

ELECTION CHANGE

REQUIRES EMPLOYER APPROVAL AND SIGNATURE

PLEASE MARK THE APPLICABLE QUALIFYING EVENT:

- ☐ Change in legal marital status – marriage, divorce or death of a spouse
- ☐ Change in number of dependents – birth, adoption, death of a dependent
- ☐ Change in employment status – termination/commencement of employment, commencement/return from unpaid leave, change in conditions of eligibility
- ☐ Change in dependent's eligibility status – attaining a specified age, marriage, ceasing to be a full-time student
- ☐ Other _____

HEALTHCARE SPENDING ACCOUNT

- ☐ **Terminate** participation in plan
- ☐ **Change** deduction amount to $_____ per pay check*

Your plan has a maximum deferral of $_____ per plan year

*If you cancel or reduce coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed.

DEPENDENT CARE SPENDING ACCOUNT

- ☐ **Terminate** participation in plan
- ☐ **Change** deduction amount to $_____ per pay check*

*You can elect a household maximum of $5000 per plan year if a single parent or if married and filing a joint return; $2500 if married filing separately.

EMPLOYEE AUTHORIZATION

*****This form must be returned to your employer*****

I certify that I have incurred the change in status as indicated above. I understand that the change in my benefit election **must be necessitated by and consistent with** the change in status and the change must be acceptable under the regulations issued by the *Department of Treasury*. I understand that my employer may require additional documentation regarding this change before it is approved.

SIGNATURE _____ DATE _____

FOR EMPLOYER USE ONLY

NEW HEALTHCARE FSA DEDUCTION AMT* _____ NEW DEPENDENT CARE FSA DEDUCTION AMT _____

NEW HCFSA ANNUAL ELECTION AMT* _____ PAYROLL EFFECTIVE DATE _____

APPROVAL SIGNATURE: _____ DATE:_____ DIVISION/LOCATION _____

*If coverage is cancelled or reduced, it cannot result in contributions for the year being less than the amount for which participant has already been reimbursed. Please contact your Account Manager or Customer Service for current account balance information.

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Fax 303-221-2785