



Horizon Blue Cross Blue Shield of New Jersey

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3 Penn Plaza East PP-05S
Newark, NJ 07105-2200
(800) 224-4426
Fax: 973-274-2215
www.HorizonBlue.com/fsa

Unreimbursed Medical / Dependent Care
Spending Account
Change in Family Status While Actively Employed

EMPLOYEE NAME (PRINT) ID #
HOME ADDRESS HOME PHONE #:
CITY STATE ZIP WORK PHONE #:
EMPLOYER NAME:

You MUST complete this form and return it to your benefits administrator within sixty (60) days of the change in family status in order to elect to participate or change your annual election amount.

Date of Change in Family Status:

Please check one of the following:

- New Election
Change my Annual Salary Deduction Amount
Suspend my Annual Salary Deduction Amount

Due to:

- Marriage
Divorce
Birth or legal adoption of a child
Death of a dependent
Change in work status of spouse
Significant change in health coverage due to spouse's employment
Change in cost or coverage of Dependent Care

New Election due to Change in Family Status

- I elect to participate in the Unreimbursed Medical Spending Account. I direct and authorize my employer to reduce my annual salary for the remainder of the calendar year by \$... I understand that my salary will be reduced in equal amounts from my regular paycheck.
I elect to participate in the Dependent Care Spending Account. I direct and authorize my employer to reduce my annual salary for the remainder of the calendar year by \$... (max.\$5,000). I understand that my salary will be reduced in equal amounts from my regular paycheck.

Change: Please complete the following:

- I elect to change my Annual Salary Deduction Amount from \$... to \$... for the Unreimbursed Medical Spending Account due to a Change in Family Status.
I elect to change my Annual Salary Deduction Amount from \$... to \$... for the Dependent Care Spending Account due to a Change in Family Status.

I understand that:

This election will remain in effect and cannot be revoked and changed during the Calendar Year, unless the revocation and new election are on account of and consistent with the occurrence of a Change in Family Status.

Employee Signature: Date:

FOR EMPLOYER USE ONLY

BENEFITS ADMINISTRATOR: DATE: