

Employer			Date of Hire
Employee's Last Name	First Name	Last Four of SSN#	
Employee's Address	City	State	Zip
Date of Birth	Email address		

If a Change of Status event occurs, only election changes that are consistent with an event that effects eligibility for coverage under an employer plan is permitted. The change in status must be on account and correspond with a change that impacts eligibility (the "Consistency Rule").

Change in Martial Status

- ☐ Change in Marital Status (marriage, death of the spouse, divorce, legal separation or annulment)

Change in Number of Tax Dependents

- ☐ Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent

Changes in Spouse or Dependent's Eligibility under an Employer's Plan

- ☐ Change in Dependent's Eligibility Requirements (ceases to satisfy, attainment of age, etc.)
☐ Judgment, decree or order including the imposition of a Qualified Medical Child Support Order
☐ Gain or loss of Medicaid or Medicare entitlement
☐ Gain of coverage through the Marketplace

Change in Employment Status that changes Eligibility Status

- ☐ Change in employment status (termination or commencement of employment by the employee, spouse or dependent)
☐ Change in Eligibility due to Change in Residency (employee, spouse or dependent)
☐ Change in work schedule (reduction or increase in hours of employment by the employee, spouse or dependent, switch between part-time and full-time, a strike or lockout, a change in worksite or commencement or return from an unpaid leave of absence)
☐ Leave of Absence (please indicate option while on leave or when returning from leave)
 ☐ Continue participation, member to make up pre-tax contributions upon return from leave
 ☐ Continue participation, member to continue contributions post tax
 ☐ Stop participation
☐ Return from Leave (Only applicable if participation stopped at commencement of LOA)

Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only)

- ☐ Change in Dependent Care Cost or Provider is replaced by another
☐

Please change my election(s) as follows:

Dependent Care Expense Account

Change my annual election for my Dependent Care Expense Account from \$ _____ to \$ _____

My new per pay date election will be \$ _____ Effective on pay date: _____

Employee's Signature: _____ **Date:** _____

IMPORTANT EMPLOYEE NOTE:

**Please complete this form and return it to Christina Rodriguez at crodriguez@chimienti.com.
 For additional information or questions, please feel free contact Chimienti & Associates at 559-733-1670.**

COVID-19 AFFIDAVIT FORM

I, _____, do hereby declare the following happened:
(printed name)

Therefore I am requesting:

Executed on this _____ day of _____ 2020, under penalty of perjury at
_____, California.

Signature

Social Security or Employee ID #

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