



# Life Status Change Form

## Reimbursement Accounts

| <b>Participant Information (Please complete and return form to your HR department.)</b>   |                         |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
|---|-------------------------|---|---------------------------------------|---|----------|--|----------|-------------------------------|----------|------------------------------|----------|--|--|
| Company Name _____  |                         |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| Last Name _____   |                         | First Name _____  | M.I. _____                            |   |          |  |          |                               |          |                              |          |  |  |
| Street Address _____  |                         | City _____  | State _____ Zip _____                 |   |          |  |          |                               |          |                              |          |  |  |
| E-Mail Address _____  |                         | Home Phone # (area code) _____  | Work Phone # (area code & ext.) _____ |   |          |  |          |                               |          |                              |          |  |  |
| Birth Date: _____/_____/_____   |                         | Employee Eligibility Date: _____/_____/_____  |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <b>Current Plan Information</b>   |                         | <b>Election Change</b>  |                                       |   |          |  |          |                               |          |                              |          |  |  |
| Plan Year Dates<br>Start : _____/_____/_____ End: _____/_____/_____   |                         | <input type="checkbox"/> <b>New Full Purpose FSA Election:</b> \$ _____<br><i>(cannot be less than ytd deposits)</i><br><b>New pay period Amount:</b> \$ _____                |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <i>(Fill in all that apply)</i>   |                         | <input type="checkbox"/> <b>New Limited Purpose FSA Election:</b> \$ _____<br><i>(cannot be less than ytd deposits)</i><br><b>New pay period Amount:</b> \$ _____             |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 40%;">Plan Type</th> <th style="text-align: left;">Current Election Amount</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Full Purpose FSA</td> <td>\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Limited Purpose FSA</td> <td>\$ _____</td> </tr> <tr> <td><input type="checkbox"/> DCRA</td> <td>\$ _____</td> </tr> <tr> <td><input type="checkbox"/> HRA</td> <td>\$ _____</td> </tr> </tbody> </table> |                         | Plan Type   | Current Election Amount               | <input type="checkbox"/> Full Purpose FSA | \$ _____ | <input type="checkbox"/> Limited Purpose FSA | \$ _____ | <input type="checkbox"/> DCRA | \$ _____ | <input type="checkbox"/> HRA | \$ _____ | <input type="checkbox"/> <b>New DCRA Election:</b> \$ _____<br><i>(cannot be less than ytd deposits)</i><br><b>New pay period Amount:</b> \$ _____ |  |
| Plan Type   | Current Election Amount |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <input type="checkbox"/> Full Purpose FSA   | \$ _____                |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <input type="checkbox"/> Limited Purpose FSA  | \$ _____                |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <input type="checkbox"/> DCRA   | \$ _____                |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <input type="checkbox"/> HRA  | \$ _____                |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
|   |                         | <input type="checkbox"/> <b>New HRA Amount:</b> \$ _____  |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <b>Life Status Change Information*</b>  |                         |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| Date of Change: _____/_____/_____   |                         | <b>Please mail or fax Completed forms to:</b><br><br><b>HealthEquity Claims</b><br><b>15 West Scenic Pointe Drive</b><br><b>Draper, UT 84020</b><br><b>Fax # 801-999-7829</b> |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <input type="checkbox"/> Birth/Adoption of Child<br><input type="checkbox"/> Marriage<br><input type="checkbox"/> Divorce<br><input type="checkbox"/> Death of spouse or dependent<br><input type="checkbox"/> Change of Insurance (for HRA only)<br><input type="checkbox"/> Termination<br><input type="checkbox"/> Other _____   |                         |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <i>*Please attach supporting documentation to this form and return to your HR department. If you have any questions regarding the required documentation, please contact HealthEquity 24 hours a day, 7 days a week at 866-346-7800.</i>  |                         |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| <i>** Note to Employer: Supporting documentation MUST be kept on file either by you or HealthEquity. Please indicate below if you will be providing HealthEquity with a copy of the documentation.</i>  |                         |   |                                       |   |          |  |          |                               |          |                              |          |  |  |
| Participant Signature _____   |                         | Date _____  |                                       |   |          |  |          |                               |          |                              |          |  |  |
| Employer Authorization _____  |                         | <input type="checkbox"/> Submitting a copy of supporting documentation to HealthEquity  | Date _____                            |   |          |  |          |                               |          |                              |          |  |  |
| HealthEquity Account Manager Signature _____  |                         | Received a copy of supporting documentation<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | Date _____                            |   |          |  |          |                               |          |                              |          |  |  |