Medcom
BENEFIT SOLUTIONS

Change in Family Status Verification Form

Employee Name	*Social Security #*	*Date of Change*	*Employer Name*		
ADDRESS CHANGE (if applicable):					
New Address	Street		City	State	Zip
Old Address	Street		City	State	Zip
Email Address:					

Description of the Change:

- ☐ Marriage
- ☐ Divorce
- ☐ Taking a Leave of Absence
- ☐ Returning from Leave of Absence
- ☐ Addition or Loss of a Dependent
- ☐ Termination of Employment of Spouse
- ☐ Commencement of Employment of Spouse
- ☐ Switch from Part Time to Full Time for Self (or vice-versa)
- ☐ Switch from Full Time to Part Time for Spouse (or vice-versa)
- ☐ Other (Please describe in detail)*

CHANGE PER PAY PERIOD	CURRENT	CHANGE TO
1. Medical FSA Deduction		
2. Dependent Care Deduction		

I hereby certify that I had a Change in Family Status as described above within the last thirty (30) days on the date recorded above. I understand that the change will be implemented only if I have made a timely request and if approved by my Employer. I further certify that the above information is true and accurate, and complete, and I understand that any pretax deductions taken from my pay as a result of this request containing erroneous information will be subject to federal income and state taxes. I hereby authorize my employer to change my payroll deductions effective the next pay cycle as indicated above.

By providing my email address above, I understand and agree that all correspondence concerning this account will be sent to me via email.

Employee Signature	Application Date
EMPLOYER USE ONLY	The above Change is: ☐APPROVED ☐DENIED EFFECTIVE DATE _____ DATE OF LAST PAYROLL DEDUCTION (if applicable) _____
EMPLOYER'S SIGNATURE	DATE

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