Tennessee Board of Regents
CHANGE IN STATUS FORM

PLEASE INDICATE THE TYPE OF CHANGE IN STATUS INCURRED:

- Marriage
- Divorce
- Death (employee, spouse, or dependent)
- Birth of child
- Adoption of child
- Beginning or end of employment of spouse
- Ineligibility of dependent (due to age, marriage or loss of full-time student status)
- From full-time to part-time employment or vice versa (employee or spouse)
- Unpaid leave of absence (employee or spouse)
- Significant change in health coverage due to spouse’s employment

This is to certify that on ______________________________ (date of event), I incurred the Change In Status checked above, and therefore wish to change my plan benefits as indicated below. I understand that the change requested must be consistent with the change status event and I have attached legal document of such change.*

Signature ______________________________ Date ______________________________

*Examples of documentation include marriage, birth, or death certificate; divorce decrees; notices of legal separation; proof of change in spouse’s employment; or adoption papers.

STATE GROUP INSURANCE PREMIUM CONVERSION

☐ I am TERMINATING my Medical Insurance.
☐ I am TERMINATING my Dental Insurance.
☐ I am CHANGING my Medical Insurance.
☐ I am CHANGING my Dental Insurance.

MEDICAL EXPENSE SPENDING ACCOUNT

☐ Terminate Account
Start Account: I wish to contribute $ ______________ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.
Change Existing Account: I wish to change from $ ______________ annual reduction to $ ______________ annual reduction amount to be taken in equal installments from

DEPENDENT CARE SPENDING ACCOUNT

☐ Terminate Account
Start Account: I wish to contribute $ ______________ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.
Change Existing Account: I wish to change from $ ______________ annual reduction to $ ______________ annual reduction amount to be taken in equal installments from

Mail completed form to:
Fringe Benefits Management Company
Change In Status Department
P.O. BOX 1878
Tallahassee, FL 32302-1878

Fax: (501)399-9333

To be completed by the PERSONNEL OFFICER:
Name __________________________
Institution __________________________
Mailing Address __________________________ Zip code __________

To be completed by the FBMC:
Date received: __________________________ Date confirmation sent: __________________________
Payroll check effective date: __________________________
Date confirmation sent to Personnel Officer: __________________________

Keep the pink copy for your records.