

## EMPLOYEE STATUS CHANGE FORM

### PERSONAL INFORMATION - PLEASE PRINT

Company Name _____	Today's Date _____
Employee Name _____	Social Security # _____

### CHANGE OF STATUS INFORMATION - Check and complete the section(s) that apply.

<input type="checkbox"/> <b>NAME CHANGE</b>
New last name: _____
New first name: _____

<input type="checkbox"/> <b>ADDRESS/PHONE CHANGE</b> (Please note Local City Tax may apply.)
New home phone number: _____
New address: _____
Street Address
_____
City State Zip

<input type="checkbox"/> <b>ADD OR CHANGE DEDUCTION AMOUNTS</b>			
	<u>DEDUCTION TYPE</u>		
___ Advance	___ Laundry	___ Shop Supplies	<u>AMOUNT</u>
___ Acct Rec.	___ Employee Loan	___ Tools	<u>PER PAY PERIOD</u>
___ Damages	___ Employee Purchase	___ Uniforms	\$ _____
	___ Other _____		\$ _____
<small>Note: Medical deductions, direct deposits, Friend of the Court, and garnishments cannot be entered on this form.</small>			
		<u>TOTAL DEDUCTION</u>	(If applicable)

### OPTIONAL BENEFIT CHANGES

<input type="checkbox"/> <b>BENEFIT CHANGE DUE TO STATUS CHANGE</b>
<p>A personal change in status (i.e. marriage, divorce, birth, adoption) must be reported by completing this section of the Employee Status Change Form and submitting it to Human Resources within 30 calendar days of the event. If submitted within 30 calendar days, eligible benefit changes will be effective the first of the month following receipt of your request, or in accordance with the Health Insurance Carriers' Policy (with the exception of births and adoptions which are effective the date of the event). If received after 30 days from the event, benefit changes can only be made during the next Annual Enrollment Period. Please contact Human Resources to obtain the necessary Health Insurance Enrollment Forms as required by the Health Insurance Carrier.</p>

<input type="checkbox"/> <b>401(k) DEDUCTION CHANGE</b>	
As soon as administratively feasible, and in accordance with the provisions on the plan, please change my salary deferral election to:	_____
	% of Gross Wages

<input type="checkbox"/> <b>AFLAC</b>
<input type="checkbox"/> Please cancel my participation in the AFLAC Program as soon as administratively feasible. <input type="checkbox"/> I am interested in learning more about the AFLAC Program, please have a representative contact me.

**SEE REVERSE FOR IMPORTANT INFORMATION  
PLEASE COMPLETE AND RETURN BOTH PAGES**

**EMPLOYEE STATUS CHANGE FORM**

**PRE-PAID LEGAL SERVICES**

- Please cancel by participation in the Pre-Paid Legal Services as soon as administratively feasible.
- I am interested in learning more about the Pre-Paid Legal Services, please have a representative contact me.

**U.S. SAVINGS BONDS**

- Please contact the U.S. Savings Bonds Program at 888.302.6637 to cancel participation.
- I am interested in learning more about the U.S. Savings Bonds Program, please have a representative contact me.

**529 COLLEGE SAVINGS PLAN**

- Please cancel by participation in the 529 College Savings Plan as soon as administratively feasible.
- I am interested in learning more about the 529 College Savings Plan, please have a representative contact me.

**FLEXIBLE SPENDING ACCOUNT - HEALTH CARE\***

- Cancel
- Enroll     \$ \_\_\_\_\_ (Annually)\*
- Change    \$ \_\_\_\_\_ (Annually)\*

**FLEXIBLE SPENDING ACCOUNT - DEPENDENT CARE\***

- Cancel
- Enroll     \$ \_\_\_\_\_ (Annually)\*\*
- Change    \$ \_\_\_\_\_ (Annually)\*\*

\* You must incur a qualifying Status Change Event to be eligible to cancel, enroll, or make a change to your existing account.  
\*\*Your annual election will be prorated over the remaining pay periods based on the Status Change effective date.

**COSTAFF CARE CARD**

- Please cancel by participation in the CoStaff Care Card as soon as administratively feasible.
- I am interested in learning more about the CoStaff Care Card, please have a representative contact me.

I authorize the elections made on this form and the payments, if applicable, required for those elections. In the event of termination of employment I agree to have the total deduction and/or remaining amounts, as listed above, withheld from my final paycheck. I certify that the information indicated on this Employee Status Change Form is complete and accurate to the best of my knowledge and I will provide any necessary documentation to verify the change in status.

**Employee Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE CONTACT COSTAFF SERVICES AT (248) 487- 4455 WITH ANY QUESTIONS.**

**FAX COMPLETED FORM TO (248) 671- 0805.**

**EMPLOYER USE ONLY**

Effective Date ____/____/____ (Check Date/Pay Period Ending/As Shown)    Sent to CoStaff: ____/____/____ CoStaff Use Only: Processed by: _____ Date: ____/____/____ <input type="checkbox"/> HR <input type="checkbox"/> Health Bills <input type="checkbox"/> COBRA <input type="checkbox"/> Carriers
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