Employee Profile & Benefit Plan Change Form

Please forward the completed form to Flyte HCM by upload to https://portal.flytehcm.com, fax to 952.666.7455, or by email to clientservices@flytehcm.com. If you have any questions, please email clientservices@flytehcm.com or call 952.746.0000.

Member Information

First Name | MI | Last Name | Social Security Number | Company Name

Update Member Demographic Information *(members may update their own address and/or email online)*

New Address _____

New Email _____

New Name _____

Pay Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly Effective Date _____

Termination of Employment

Last Day Worked _____ Last Day of Plan/Insurance Coverage *(if applicable)* _____

Date of Final Payroll Deductions *(if applicable)* _____ *Please list final YTD total deductions below*

Dependent Care _____ Health Savings Account _____

Health FSA _____ Pretax Group Insurance Premiums _____

Parking Expenses _____

Transit Expenses _____

Individual Insurance Premium (iPOP) _____
Does amount collected cover final monthly premium?
☐ Yes - Employer pays premium ☐ No - Return to employee (employee pays)

COBRA *(select one)*

☐ Flyte HCM administers COBRA for this employer. The employer will submit COBRA paperwork with detailed insurance benefit information to Flyte HCM for processing along with this form.

☐ Flyte HCM does NOT administer COBRA for this employer. COBRA paperwork will be submitted to the administrator for processing. Flyte HCM will be notified if the former employee elects COBRA coverage of applicable benefits.

Changes in Status Affecting Plan Coverage or Payroll *(including Qualified Status Change Events)*

Please complete the sections below for each applicable benefit plan. As different benefits are governed by different sets of federal regulations, different information may be required. Please see attached chart for list of events and allowable changes to enrollment and pretax deductions. If a Qualified Event is required to make a change, the change must be submitted within thirty (30) days of the Qualified Event. If you feel the form below does not provide Flyte HCM with all the information about the particular event, please feel free to communicate any additional information in the email, fax coversheet, etc.

Change Code _____ **Event Name** _____ **Date Event Occurred** _____

Month Change Takes Effect *(if applicable)* _____ **Payroll Date Change Takes Effect** *(if applicable)* _____

Section 125 Flexible Benefits Plan (FSA, DEPCARE) *(Qualified Event Required)*
- ☐ Health FSA: New Election _____ New Deduction _____
- ☐ Dependent Care: New Election _____ New Deduction _____

Section 132 Parking & Transportation Plan
- ☐ Parking: New Election _____ New Deduction _____
- ☐ Transportation: New Election _____ New Deduction _____

Individual Insurance Premium (iPOP) *(Qualified Event Required if Pretax)*
- ☐ New Monthly Premium _____ New Deduction _____
- ☐ New Carrier _____

Pretax Group Insurance Premiums *(Qualified Event Required)*
- ☐ New Projected Total Plan Year Deductions _____

Health Savings Account (HSA)
- ☐ New Deduction _____
- ☐ New Coverage Level ☐ Single ☐ Family
- ☐ No Longer Eligible - Final Date of Eligibility _____

Health Reimbursement Arrangement (HRA, Section 105 Plan)
- ☐ Drop Spouse/Dependent from Coverage _____
- ☐ Drop Coverage - Final Date of Coverage _____

Please attach a Plan Participation Agreement if adding a spouse or dependent.

Minimum Essential Coverage (MEC)
- ☐ Drop Spouse/Dependent from Coverage _____
- ☐ Drop Coverage - Final Date of Coverage _____

Please attach a Plan Participation Agreement if adding a spouse or dependent.

Signature of Member *(not required on termination of employment)* Date

Signature of Payroll / HR Officer | Name of Payroll / HR Officer *(printed)* | Date