

FLEXIBLE BENEFITS PLAN CHANGE IN STATUS FORM

Employer Name: _____

Employee Name: _____

Employee Address: _____

Employee Social Security Number or ID: _____

Plan Year _____

Plan: Healthcare

Dependent Day Care

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status events.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status event, affect eligibility for benefits and that the change must be acceptable under the Regulations issued by the Department of Treasury as well as made in a timely basis from the date of the event.

I certify that I have incurred the following change in status:

_____ Marriage

_____ Divorce, Legal Separation or Annulment

_____ Birth, adoption or placement for adoption of a child

_____ Death of my spouse and/or dependent

_____ Termination or commencement of employment by my spouse or dependent

_____ Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse, or dependent or reduction or increase in hours, strike or lockout

_____ I, my spouse or dependent has taken or returned from an unpaid leave of absence

_____ A change in the residence or worksite of myself, my spouse or dependent

_____ My dependent satisfies or ceases to satisfy the requirements for coverage

_____ Other: _____

The Event listed above occurred on this date: _____

Current Annual Election: _____

New Annual Election: _____

The Administrator may require you to provide evidence to document the event that requires the change of election. Changes must be submitted within 30 days of the event except for a birth or adoption, which allows up to 60 days.

Employee's signature

Date _____

Administrator

Date _____

For Administrative Use Only - Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator.

Effective Date: _____

Per Pay Period Amount: _____