SECTION 125 CAFETERIA PLAN

CHANGE IN STATUS/TERMINATION ELECTION FORM

Complete this form when a change in status has occurred which affects your Cafeteria Plan election. All changes must be due to and consistent with the change in status.

Company Name	**Effective Date of Change**
Employee Name	**Social Security Number**
Employee Address	**Phone Number**
If Terminating, Date of Last Deduction	

As a participant in the Cafeteria Plan, I am entitled to revoke my prior benefits election and enter into a new election in the event of certain changes in status. I understand that the change in my benefits election must be due to and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

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

Change in Marital Status

☐ Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment

Change in Number of Tax dependents

☐ Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent

Changes in Spouse or Dependent's Eligibility under an Employer's Plan

☐ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status
☐ Judgment, decree or order including the imposition of a Qualified Medical Child Support Order
☐ Gain or loss of Medicaid or Medicare entitlement
☐ Entitlement to COBRA
☐ Special requirements relating to the Family and Medical Leave Act (FMLA)

Change in Employment Status That Changes Eligibility Status

☐ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.
☐ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.
☐ Change in eligibility due to change in residency of the employee, spouse or dependent.

Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only)

☐ Significant cost increase in your or your dependent's coverage
☐ Significant curtailment of your or your dependent's coverage
☐ Addition or elimination of benefit package option under your or your dependent's employer's plan
☐ Change in coverage or open enrollment of spouse or dependent under other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.
☐ Dependent care provider is replaced by another.

Please change my election(s) as follows:

Premium Savings Account: Change insurance premiums to $_____ per pay period.

Health Care Expense Account: Change my annual election from $_____ to $_____.
My new per pay period election will be $_____ effective with the_____ payroll.

Dependent Care Assistance Program: Change my annual election from $_____ to $_____.
My new per pay period election will be $_____ effective with the_____payroll.

_____ _____
Employee Signature Date

Accepted and agreed to by: _____ _____
Company Representative Date