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.

Employee Name _____ **Company Name** _____

Employee Home Address _____

Home Phone Number _____ **SS Number** _____

Effective date of change _____ **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 legal *marital status* including marriage, death of the spouse, divorce, legal separation or annulment.

☐ Change in the *number of tax dependents* including birth, adoption, placement for adoption or the 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:

Change **Insurance Premiums** to $_____ per pay period.

Change my annual election for my **Medical Reimbursement Account** from $_____ to $ _____

My new per pay period election will be $ _____ effective with the _____ payroll

Change my annual election for my **Dependent Care Assistance Program** 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