

FLEX BENEFIT ADMINISTRATORS

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Section 125 Cafeteria Plan

Change in Status Form (do not use for employee termination)

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: _____ Location _____

Participant's Name: _____

Social Security Number _____ or Employee Number _____

Effective Date Of Change _____

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. I understand that the change in my benefit election must be due to and consistent with the change in status, the change must be acceptable under the Regulations issued by the Department of Treasury and that the change is within 30 days of the event.

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

- | | |
|--|--|
| <input type="checkbox"/> Change in Marital Status | Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment. |
| <input type="checkbox"/> Change in Number of Tax Dependents | Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent. |
| <input type="checkbox"/> Changes in spouse or Dependent's Eligibility under an Employer's Plan | <ul style="list-style-type: none">• 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). |
| <input type="checkbox"/> Change in Employment Status that Changes Eligibility Status (if employee termed, use the Termination Form) | <ul style="list-style-type: none">• Change of employment status, such as termination or commencement of employment by the 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. |
| <input type="checkbox"/> Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only) | <ul style="list-style-type: none">• 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:

- | | |
|---|---|
| <input type="checkbox"/> Insurance Premium Account: | Change my <i>insurance premiums</i> to \$_____ per pay period. |
| <input type="checkbox"/> Health Care Expense Account | Change my annual election for my <i>Health Care Expense Account</i> from \$_____ to \$_____
My new per pay period election will be \$_____ effective with the _____ payroll |
| <input type="checkbox"/> Child/Elder Care Expense Account | Change my annual election for my <i>Child/Elder Care Expense Account</i> from \$_____ to \$_____
My new per pay period election will be \$_____ effective with the _____ payroll |

Signature of Employee

Date

Employer Representative

Date

Employer Representative to fax form to Flex Benefit Administrators at (713) 460-3550. Forms received in by the 25th will be reflected on following month's listing