Change in Life Status Form

Employer Name: ________________________________ **Effective Date:** ____________

Employee Information

Name: ____ Social Security #: _______ - _____ - __________
(Last, First, Middle Initial)

Home Address: ___________________________________ Date of Hire: _____/_____/__________
(Street Address)

___________________________________ Marital Status (check one): [ ] Single [ ] Married
(City, State ZIP Code)

Change In Life Status

Participants in a Cafeteria Plan may only change their annual salary reduction if they experience a "Change in Life Status." Please check the box of the Change in Life Status that you/your spouse experienced.

[ ] Marriage
[ ] Divorce/Legal Separation
[ ] Birth/Adoption of a Child
[ ] Death of Spouse/Dependent
[ ] Loss of "Dependent" Status
[ ] Medicare Entitlement
[ ] Daycare Cost change
[ ] Spouse Became Unemployed
[ ] Spouse Became Employed
[ ] Spouse - Change in Job
[ ] Employee - Part-time to Full-time or Full-time to Part-time
[ ] Change in Residence (Dependent Care Account only)
[ ] Change in daycare provider
[ ] Leave of Absence (LOA)
[ ] Employee Receives a Qualified Medical Child Support Order

A Participant who experiences a Change in Life Status may make a change in his existing election provided that such change must be consistent with the Change in Life Status. The Plan Administrator shall determine whether a Change in Life Status has occurred and whether a Participant's change in coverage is consistent with such Change in Life Status. You have thirty days from the date of the Change in Life Status to submit this complete form.

Annual Reduction Change

By changing your Annual Salary Reduction, you will be changing your reduction by Pay Period. You may not change your Annual Salary Reduction to an amount that is less than the amount already reimbursed by your account. You may want to review your account balance(s) from your web portal. Please enter your old Annual Salary Reduction and the amount you would like to change it to.

Check Appropriate Plan	Old Annual Reduction	New Annual Reduction
[ ] Medical Reimbursement Plan	$____________	$____________
[ ] Dep. Care Reimbursement Plan	$____________	$____________

Salary Reduction Agreement

With this authorization, I am directing my employer to reduce my annual compensation by the new Annual Salary Reduction amount shown and reimburse me upon submitting eligible receipts. I authorized the company to make adjustments to my reduction per pay period so that the new annual reduction amount is achieved. I also understand that this new election is irrevocable and can only be changed if another Change in Life Status is experienced.

________________________________ (Signature) ______________ (Date)

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