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:

☐ 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 (if employee termed, use the Termination Form)	• 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.
☐ 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:

☐ Insurance Premium Account:	Change my *insurance premiums* to $_________________ per pay period.
☐ Health Care Expense Account	Change my annual election for my *Health Care Expense Account* from $_________ to $_________ My new per pay period election will be $___________ effective with the ___________ payroll
☐ Child/Elder Care Expense Account	Change my annual election for my *Child/Elder Care Expense Account* 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