# Change in Status/Termination Election Form
# Section 125 Cafeteria Plan

**Please return this form to your Employer**

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|---|---|
| Employer Name: | |
| Employee Name: | Phone #: |
| Social Security #: | Date of Birth: |
| Address: | |
| Effective Date of Change in Status: | If terminating, date of last deduction: |

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 benefits election must be due to and consistent with the changes 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 due to:**

☐ Marriage ☐ Death of a Spouse ☐ Divorce ☐ Legal Separation

**Change in Number of Dependents due to:**

☐ Birth ☐ Death ☐ Adoption/Placement for Adoption

**Change in Spouse or Dependent's Eligibility Under an Employer's Plan**

- ☐ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirement 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 Qualified Medical Child Support Order.
- ☐ Gain or loss of Medicaid or Medicare entitlement.
- ☐ Entitlement to COBRA.
- ☐ Special requirement 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, 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 provider that the employee, spouse or dependent elects coverage under the dependent's plan.
- ☐ Dependent care provider is replaced by another.

**Change in Election due to Discrimination Testing**

- ☐ Reduction in elections to comply with nondiscrimination rules.

## *Please change my election(s) as follows:*

**Premium Savings Account**

Change insurance premiums to $_____ per pay.

**Health Care Expense Account**

Change my annual election for my **Health Care Expense Account** from $_____ to $_____.
My new per pay period elections will be $_____ effective _____ payroll.

**Dependent Care Assistance Program**

Change my annual election for my **Dependent Care Assistance** from $_____ to $_____.
My new per pay period elections will be $_____ effective _____ payroll.

| | |
|---|---|
| **Employee Signature:** | **Date:** |
| **Accepted and agreed to by Company Representative:** | **Date:** |