CAFETERIA PLAN CHANGE REQUEST FORM

This form is required for changing benefit elections outside of the open enrollment period.

Employer:	***Plan Year:***
Name:	***Employee ID: (SSN)***
Mailing Address:	***Phone Number:***
City: ***State:*** ***Zip:***	***Email Address:***

When a change in status event occurs, employees are allowed to make changes consistent with the event. The change in status must be consistent with IRS Regulations "consistency rule", i.e. affect coverage eligibility of the employee, spouse or dependent.

CHANGE IN STATUS: (Check all that apply)

❑ Change in employee's legal marital status-including marriage, divorce, death of spouse, legal separation and annulment.

❑ Change in number of dependents-including birth, death, adoption and placement of adoption.

❑ Change in employment status of the employee, spouse or dependent that affects benefit eligibility-Including termination or commencement of employment; a strike or lockout; commencement of or return from unpaid leave of absence; reduction or increase of hours of employment.

❑ Dependent satisfies (or ceases to satisfy) dependent eligibility requirements- an event that causes the dependent to satisfy (or cease to satisfy) the requirements for coverage due to attainment of age, gain or loss of student status, marriage or similar circumstances.

❑ Change in residence of an employee, spouse or dependent that affects the employee's eligibility for coverage.

❑ Change in cost or coverage for dependent care. *(Can only change daycare election)*

❑ Change in insurance cost or scope of coverage. *(Can only change insurance election)*

FMLA OR UNPAID LEAVE OF ABSENCE

❑ Revoke my existing election (Can only elect for FMLA leave)

❑ Prepay option: I wish to accelerate my deductions, prior to my leave without pay to ensure I can submit claims during my leave. I understand that this will increase my per pay period amount. For dependent care I understand that if I am not working during my leave, I will not be eligible for reimbursement for dependent care expenses.

❑ Pay as you go option: I wish to pay my per pay period deduction on an after-tax basis during my leave to ensure I can submit claims during my leave. I will pay this directly to my employer before each pay date.

❑ Catch up option: I understand that the expense I incur during my leave will not be reimbursed unless I return to work during the plan year and have deductions withheld to fulfill my annual election.

Brief Description of Change of Status:

_____

_____

_____

Date of Qualifying Event:

_____/_____/_____

(Change must be made within 30 days of event)

First Payroll Date Affected By this Change of Election:

_____/_____/_____

Benefit Type	Current Per Pay Period ER Election	Current Per Pay Period EE Election	Current Annual Election	New Per Pay Period ER Election	New Per Pay Period EE Election	New Annual Election
Reimbursement Plans						
Health Care FSA						
Dependent Care						
Employer Sponsored Premiums						
Insurance Premium for Medical			N/A			N/A
Insurance Premium for Dental			N/A			N/A
Insurance Premium for Vision			N/A			N/A
Insurance Premium for Other			N/A			N/A

I, _____, understand that federal regulations prohibit me from changing the election that I made after the beginning of the plan year, with the exception of experiencing a qualifying event. Accordingly, I certify that, effective as of the date indicated above, I have incurred the following change in status and notified my plan administrator within 30 days that I wish to change my election as indicated above.

Employee Signature:_____ **Date:** _____

Company Authorization:_____ **Date:** _____

This Plan Administered by Professional Benefit Services, Inc.

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