Cafeteria Plan
Change Form

Group Name:_____ 1st Payday affected date:_____/_____/_____

Participant Name:_____ SS#_____-_____-_____

Address Change: _____ Home Phone: _____

_____ Work Phone: _____

Under IRS Guidelines, to amend or revoke an election under a Section 125 Cafeteria Plan, you as a participant, must have incurred a family status change or an employment status change. The status change is effective the first day of the month following the employment or family status change. If you qualify to amend or revoke an election, complete the following within 30 days of the qualifying event.

Family Status Change

I, as the participant, have incurred the following family status change during the current plan year.

Change must be consistent with family status change ie., birth of a child = change from single health insurance to family.

( ) Adoption/Birth
( ) Death
( ) Legal marital status change
( ) Other_____

( ) Dependent satisfies eligibility requirements
( ) Spouse begins/ends work
( ) FLMA Leave
( ) Other_____

Please change my deduction **per pay period** as follows: (No. of pay periods remaining in plan year = _____)

Benefit	Current	Revised	Benefit	Current	Revised
Health Insurance	_____	_____	Cancer	_____	_____
Life Insurance	_____	_____	AD&D	_____	_____
Dental Insurance	_____	_____	Supp. Hosp. Ins.	_____	_____
Out of pocket Medical	_____	_____	Other_____	_____	_____
Dependent Care	_____	_____	Other_____	_____	_____

Employment Status Change

The participant has incurred an employment status change due to one of the following:

( ) Disability
( ) Lay off
( ) Leave of Absence
( ) Retirement

( ) Termination (Date _____)
( ) Significant benefit cost/coverage change
( ) Change in work schedule
( ) Other_____

Claims may continue to be submitted for reimbursement through the end of the plan year for services rendered prior to the change in employment status.

I verify that I have read and understand the information on the page and that it is true and correct to the best of my knowledge. I understand that this information will be submitted to Select Data Service Administrators, P.O. Box 2076, Batesville, AR 72503.

_____ _____

Participant's Signature Date Personnel Date

1 COPY-SDSA **1 COPY-Personnel** **1 COPY-Employee**