

Cafeteria Plan Change of Status Form

(Please complete this form and return it to your Human Resource Department)



1 Personal Information

Employee Name _____

Company Name _____

Street Address, City, State, Zip _____

Current Date _____

Date of Event/Termination _____

Social Security Number _____

2 Qualifying Event

- Change of Status - List all dependents (including Spouse): i.e. Marriage, Divorce, Death, Legal Separation, Birth, Adoption, No Longer Dependent, Employment Change, Spousal Employment Change, etc.

Full Name	Date of Birth	Relationship	Reason for Change of Status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Change Cost or Provider – Dependent Care i.e. Change of Day Care Provider, Cost Increases or Decreases

- Termination of Employment

3 Change of Benefit

The payday that the new deduction begins: _____

Date of last payroll deduction (if termination of employment): _____

	Prior Annual Election Amount	New Annual Election Amount	Frequency of Withholding (weekly, semi-monthly, etc.)
Health Care Expense	_____	_____	_____
Day Care Expense	_____	_____	_____

4 Employee Signature/Company Representative Signature

Employee Signature _____

Date _____

Company Representative Signature _____

Date _____