



CHANGE OF STATUS FORM

SECTION 125 CAFETERIA PLAN
FAX NUMBER 916/363-2117; TELEPHONE NUMBERS 916/363-2101; 800/800/2090
www.pacificbenefits.com

(RETURN TO THE HUMAN RESOURCE DEPARTMENT WHEN COMPLETED)

COMPANY NAME: _____ DIVISION: _____

NAME: _____ SOCIAL SECURITY NO. _____ - _____ - _____

(1) ADDITION/TERMINATIONS (complete sections 1 and 3)

____ (A) ADDITION TO THE PLAN: date of birth _____ date of hire _____

____ (B) TERMINATE EMPLOYMENT: date of termination _____ date of last payroll deduction: _____

If terminated, please provide Employee's Home Address: _____

(2) PERMISSIBLE STATUS CHANGES: (Check reason and complete Coverage Section below)
Please note that the status change must be "consistent with and on account of" the qualifying event (e.g. a change in insurance rates would not permit a change in child care). **Status changes are an exception to the general rule that once you make your annual election it cannot be changed until plan year-end.**

- | | |
|--|--|
| <input type="checkbox"/> C. Cobra Event | <input type="checkbox"/> L. Judgment Decree Or Court Order |
| <input type="checkbox"/> D. Marriage Or Divorce | <input type="checkbox"/> M. Family Dependent's Status Change |
| <input type="checkbox"/> E. "Grandma Change" (Dependent Care) | <input type="checkbox"/> N. Employee Or Spouse Changes From Full-Time to Part-Time (causing a change in eligibility) |
| <input type="checkbox"/> F. Birth, Adoption Or Placement For Adoption Of a Child | <input type="checkbox"/> O. Vendor Rate Change (Ins. Or Dep. Care) |
| <input type="checkbox"/> G. Commencement Of Or Termination Of adoption proceedings | <input type="checkbox"/> P. Entitlement to Medicare, Medicaid, or other Government Benefit Plans |
| <input type="checkbox"/> H. Death Of Spouse Or Child | <input type="checkbox"/> Q. Job Site Transfer or Residence Change (only if eligibility for insurance changes) |
| <input type="checkbox"/> I. Spouse/Dependent gains eligibility under their Employer's plan | <input type="checkbox"/> R. Clerical/Administrative changes |
| <input type="checkbox"/> J. Termination Of Spouse's Or Dependent's employment | <input type="checkbox"/> S. Eligibility for Insurance Change (Employee or Dependent) |
| <input type="checkbox"/> K. Away on or returning from a leave of absence | |

(3) COVERAGES: (Per pay period)

(C) Change
(A) Add
(T) Terminate
LOA Return
Revised Annual
Election \$

BENEFIT	OLD DEDUCTION	NEW DEDUCTION	(C) Change (A) Add (T) Terminate	LOA Return Revised Annual Election \$

ATTENTION:

ALL STATUS CHANGES MUST BE APPROVED BY THE ADMINISTRATOR AND ARE ONLY EFFECTIVE FOR **FUTURE PAY PERIODS**. ALL CHANGES MUST BE REPORTED TO THE HUMAN RESOURCE DEPARTMENT WITHIN **30 DAYS** OF THE QUALIFIED EVENT.

EMPLOYEE SIGNATURE: _____ DATE: _____
I CERTIFY THAT EFFECTIVE ____/____/____, I HAD A CHANGE IN FAMILY AND/OR EMPLOYMENT STATUS AS INDICATED ABOVE AND I REQUEST THAT CHANGES IN MY BENEFITS BE MADE AS INDICATED.

FOR HUMAN RESOURCE ONLY:

EFFECTIVE PAYDATE OF CHANGE: ____/____/____
Prepared By: _____