Salary Reduction Agreement Change and Revocation Form

PART 1. EMPLOYER/EMPLOYEE INFORMATION

Employer _____ Employee _____ SS # _____

PART 2. EMPLOYEE TERMINATION INFORMATION

Employee termination date: _____/_____/_____ Date of last paycheck with pre-tax deduction: _____/_____/_____

Amount deducted to date for Health Care FSA_____ Amount deducted to date for Dependent Care FSA _____

Forwarding Address: _____

If applicable, are you electing to continue a FSA (Flexible Spending Account)? ❑YES ❑NO

PART 3. USE THIS SECTION FOR ELECTION CHANGE DUE TO CHANGE IN FAMILY STATUS.

(Change must be consistent with the qualifying event)

Date family status change occurred: _____/_____/_____

Date of first paycheck with pre-tax deduction reflecting change of election: _____/_____/_____

Name of family member and their relationship: _____

Check the appropriate box to indicate a Change in Status or a Change in Cost or Coverage on the above date (check one):

- **Changes in Status**
  - **Change in Marital Status** ❑ Marriage ❑ Divorce ❑ Death of Spouse
  - **Change in Number of Tax Dependents** ❑ Birth ❑ Adoption ❑ Placement for Adoption ❑ Death of Dependent
  - **Change in Employment Status That Affects Eligibility**

	You	Your Spouse or Dependent
Termination of Employment	❑	❑
Commencement of Employment	❑	❑
Part-time to Full-time	❑	❑
Full-time to Part-time	❑	❑
Strike or Lock-Out	❑	❑
Commencement of unpaid leave of absence	❑	❑
Return from unpaid leave of absence	❑	❑
Change in Worksite	❑	❑
Other (Salaried to Hourly, etc.)	❑	❑

  - **Change in Spouse or Dependent's Eligibility Under an Employer's Plan**
    - Loses eligibility (age, student status, marital status) ❑
    - Gains eligibility (age, student status, marital status) ❑
  - **Change in Residence Affecting Eligibility** ❑ ❑
- **Changes in Cost or Coverage** (Note: Changes in Cost or Coverage do *not* allow for changes in health FSAs.)
  - **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** ❑

Please explain the Change in Status or Change in Cost or Coverage event(s) marked above on which you are basing your request for a mid-year coverage change and describe how the requested change is consistent with the event.

_____

PART 4. I HEREBY REVISE MY BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT UNDER MY EMPLOYER'S CAFETERIA PLAN WITH RESPECT TO THE FOLLOWING COVERAGE.

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above.

PREMIUM CONVERSION	**Old Election**	**New Election**
Group Medical	$_____	$_____
Group Dental	$_____	$_____
Group Term Life	$_____	$_____
Other	$_____	$_____
HEALTH SAVINGS ACCOUNT (HSA)	$_____	$_____
HEALTH CARE FSA	$_____	$_____
DEPENDENT CARE FSA	$_____	$_____

I have examined this authorization to modify my Salary Reduction Agreement, and to the best of my knowledge, it is true, correct, and complete.

_____ _____

Employee's Signature Date

Accepted and agreed to:

_____ _____

Employer's Signature Date

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