

Advantage™

ADMINISTRATORS

Section 125 Cafeteria Plan Change in Status/Termination Election Form

Complete this form when a change in status has occurred which affects your Cafeteria Plan election. All changes must be due to and consistent with the change on status.

Company Name _____

Employee Name _____ Social Security Number _____

Effective Date of Change _____ If terminating, date of last deduction _____

As a participant in the Cafeteria Plan, I am entitled to revoke my prior benefits election and enter into a new election in the event of certain change in status. I understand that the change in my benefits election must be due to and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in status (check all that apply):

Change in Marital Status

- Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment

Change in Number of Tax Dependents

- Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent

Change in Spouse or Dependent's Eligibility Under an Employer's Plan

- Changes in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status
- Judgement, decree or order including the imposition of a Qualified Medical Child Support Order
- Gain or loss of Medicaid or Medicare entitlement
- Entitlement to COBRA
- Special requirements relating to the Family and Medical Leave Act (FMLA)

Change in Employment Status that Changes Eligibility Status

- Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent
- Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.
- Change in eligibility due to change in residency of the employee, spouse or dependent

Change in Cost or Coverage (applicable for Health insurance and dependent care assistance account elections only)

- Significant cost increase in your or your dependent's coverage.
- Significant curtailment of your or your dependant'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 provided that the employee, spouse or dependent elects coverage under the dependent's plan.
- Dependent care provider is replaced by another.

Please change my election(s) as follows:

Premium Savings Account

Change insurance premiums to \$ _____ per pay period

Health Care Reimbursement Account

Change my annual election for my Health Care Reimbursement Account from \$ _____ to \$ _____.

My new per pay period election will be \$ _____.

Dependent Care Assistance Program

Change my annual election for my Dependent Care Assistance Account Program from \$ _____ to \$ _____.

My new per pay period election will be \$ _____.

Participant Signature: _____ **Date:** _____

Please Return Form to: Advantage Administrators
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Fax: 319-352-2610
E-mail: customercare@advantageadmin.com