



Employee Information

Employer Name: _____

Employee Name: _____ Social Security Number: _____

Street Address: _____ Daytime Phone Number: _____

City: _____ State: _____ Zip Code: _____

Date of Change: _____

Nature Of Change

- Enroll in Medical Expense Account
- Change Medical Expense Account pre-tax deduction amount)
- Discontinue participation in Medical Expense Account

Qualifying Life Status Change

- Change in marital status
- Change in number of dependents
- Spousal employment or coverage: changed terminated
- Change in number of work hours for: self spouse or dependent
- Dependent: no longer qualifies as a dependent is eligible for another health plan
- Change in plan co-pays, deductibles, or other out of pocket expenses
- Other: _____
(Explanation required)

Authorization

I have reviewed the terms of my Employer's Flexible Benefits Plan. I understand that the changes I direct on this form will be deducted from my compensation on a pre-tax basis and the deductions cannot be changed until the next plan year unless there is a qualifying change in status. I have read and agree to the terms of participation.

I authorize my employer to change my contribution to the following amount:

\$ _____ per pay period x _____ remaining pay periods = \$ _____ Remainder of Plan Year Total

Employee's Signature

Date

For Employer Use Only:					
Company Name:	Division:	Effective Date:	Pay Cycle:	Entered in Payroll:	Initials: