



**EMPLOYEE CHANGE FORM
FOR
THE CAFETERIA PLAN**

I. Participant Information:

Participant's Name

Employer Name

Participant's Home Address

Social Security Number

Birth Date

Home Phone

II. Change Information: (Please check one.)

Termination

Termination date:_____.

Payroll date for last Flex deduction:_____.

Amount of remaining plan year pretax deduction amount taken off last paycheck_____.

Leave of Absence (LOA)

Payroll date of last Flex deduction:_____.

Amount of last deduction:_____.

Return from Leave of Absence

New Payroll deduction date:_____.

Please fill out section III.

Status Change (other)

Describe the status change:_____.

Payroll deduction date of new Flex amount_____.

Please fill out section III.

III. New Flex Deduction Amounts:

A. Health FSA Benefit:

Employee \$ _____/pay period New Annual amount \$ _____

B. DCAP Benefit:

Employee \$ _____/pay period New Annual amount \$ _____

IV. Authorization:

The above changes shown are hereby authorized to be made for the above named employee. This authorization is made by the Plan Administrator of the Cafeteria plan.

Employer Signature

Date