

# SECTION 125 FLEXIBLE BENEFIT PLAN CHANGE OF STATUS FORM

Employer			
Employee's Last Name	First Name	Employee's SS#	
Employee's Address (Street)	City	State	Zip

### CHANGE CODES

- |  |   |
|--|---|
| <input type="checkbox"/> PLAN ANNIVERSARY CHANGES<br><input type="checkbox"/> MARRIAGE<br><input type="checkbox"/> BIRTH OR ADOPTION OF A CHILD<br><input type="checkbox"/> EMPLOYMENT OF SPOUSE<br><input type="checkbox"/> AWAY ON LEAVE OF ABSENCE <i>Date: ___/___/___</i><br><input type="checkbox"/> FAMILY DEPENDENT'S STATUS CHANGE<br><input type="checkbox"/> VENDOR RATE CHANGE (Applies to Premiums, and Day Care Providers) | <input type="checkbox"/> TERMINATE EMPLOYMENT<br><input type="checkbox"/> DIVORCE<br><input type="checkbox"/> DEATH OF SPOUSE OR CHILD<br><input type="checkbox"/> TERMINATION OF SPOUSE'S EMPLOYMENT<br><input type="checkbox"/> BACK FROM LEAVE OF ABSENCE <i>Date: ___/___/___</i><br><input type="checkbox"/> CHANGE FROM Full-Time TO Part-Time STATUS<br><input type="checkbox"/> CHANGE IN SPOUSE'S CAFETERIA PLAN |
|--|---|

EXPENSE TYPE (Please Check)	NEW DEDUCTION AMOUNT <i>Per Pay Period</i>	or <b>DELETE</b>
HEALTH INSURANCE PREMIUMS	\$	\$
HEALTH SAVINGS ACCOUNT DEDUCTIONS TO BANK	\$	\$
DEPENDANT DAYCARE EXPENSES	\$	\$
UNREIMBURSED MEDICAL EXPENSES	\$	\$
LIMITED MEDICAL EXPENSES <i>VISION and/or DENTAL ONLY</i>	\$	\$

Annual Elections can only be changed upon completion and submission of this form within 30 days of status change.

I certify that effective \_\_\_/\_\_\_/\_\_\_, I had a change in family and/or employment status as noted above and request that changes in my benefits be made as indicated. Change to be effective on Pay Date \_\_\_/\_\_\_/\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## ALL VALLEY ADMINISTRATORS, LLC

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