

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

EXPENSE TYPE TO BE (please circle) ADDED/CHANGED/DELETED:	NEW DEDUCTION AMOUNT <i>Per Pay Period</i>	or DELETE
HEALTH INSURANCE PREMIUMS	\$	\$
DEPENDANT DAYCARE EXPENSES	\$	\$
UNREIMBURSED MEDIAL EXPENSES	\$	\$
LIMITED MEDICAL EXPENSES <i>VISION/DENTAL ONLY</i>	\$	\$

Annual Elections can only be changed upon completion of this form. Please make changes 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.

Signature

Date

ALL VALLEY ADMINISTRATORS, LLC

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