

PART I. CHANGE OF STATUS

EMPLOYER INFORMATION	EMPLOYEE INFORMATION
Employer Name: _____	Employee Name: _____
Group Tax I.D.: _____	Employee SSN: _____
	CHANGE OF STATUS DATE: _____

TYPE OF STATUS CHANGE: *(Select Applicable Status Change)*

- A. Change in legal marital status. *Select the applicable change below.*
 Marriage Death of Spouse Divorce Legal Separation Annulment
- B. Change in number of dependents a participant has including a change due to: *(Select the applicable change below. (Complete Dependent Section below.)*
 Birth Adoption Placement for Adoption Death of a Dependent
- C. Change in the Employment Status of the participant, participant's spouse or a dependent. *(This includes a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in work site.) (Provide dependent's name in Dependent Section, if applicable.)*
 Explain Employment Status Change: _____
- D. Change in Dependent Status for Eligibility Purposes. *(A qualifying status change occurs if a dependent satisfies or ceases to satisfy eligibility requirements on account of attainment of age, student status, or any similar circumstances.) (Complete Dependent Section below.)*
 Explain Dependent Status Change: _____
- E. Change of Residence of the participant, the participant's spouse, or a dependent.
- F. Commencement or Termination of Adoption Proceedings.
- G. A judicial decree that requires health insurance coverage for a participant's dependent child or foster child resulting from: *Select the applicable action. (Complete Dependent Section below.)*
 Divorce Legal Separation Annulment
 Change in Legal Custody, including Qualified Medical Child Support Order.
- H. For health insurance coverage elections only, enrollment of the participant, the participant's spouse, or a dependent for health benefit coverage under Medicare or Medicaid. *(Complete Dependent Section, if applicable.)*
Does not apply to LifeRe Dental or Vision benefits.
- I. Significant Changes in Cost. Does not apply to LifeRe Dental or Vision benefits.
- J. Significant Changes in Coverage.

DEPENDENT(S) SECTION:

Name of Applicable Dependent	Relationship	Date of Birth	Sex

I hereby authorize a change to the reduction in my salary in accordance with my benefit/status change as shown under Part 1 Change of Status section of this form.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

CHANGE OF STATUS AND ELECTION CHANGE FORM

PART II. ELECTION CHANGE FORM FLEXIBLE BENEFIT CAFETERIA PLAN

EMPLOYER INFORMATION	EMPLOYEE INFORMATION
Employer Name: _____	Employee Name: _____
Group Tax I.D.: _____	Employee SSN: _____
Address: _____	*Address: _____
Street	Street
City State Zip	City State Zip
	* Is the address above an address change? <input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZED CONTRIBUTIONS		
Current Benefits	Current Deductions	New Deductions
Medical -	\$	\$
Dental -	\$	\$
Vision -	\$	\$
Specified Disease -	\$	\$
Voluntary Products -	\$	\$
	\$	\$
	\$	\$
	\$	\$
Medical Reimbursement - LifeRe <small>Maximum annual allowable contribution is limited, please check with your employer.</small>	\$	\$
Dependent Care Reimbursement - LifeRe <small>Maximum Annual Amount cannot exceed \$5,000 if Married Filing Jointly, \$2,500 if Married Filing Separately.</small>	\$	\$

List any Dependent(s) to be added in the Dependent Section located in Part I of this form.

I hereby request the election of benefits shown above as a result of a change in my status as shown under Part 1. Change of Status section of this form:

CHANGE OF STATUS DATE: _____

EFFECTIVE DATE OF DEDUCTION CHANGE: _____

EMPLOYEE SIGNATURE: _____

DATE: _____