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FLEX PLAN CHANGE FORM

EMPLOYER: _____

PLAN YEAR: _____

EMPLOYEE NAME: _____

SOCIAL SECURITY #: _____

ADDRESS: _____

NEW ADDRESS? YES _____ NO _____

CHANGE DUE TO ONE OR MORE OF THE FOLLOWING: *

_____ MARRIAGE/DIVORCE

_____ BIRTH/ADOPTION

_____ DEATH

_____ SPOUSE EMPLOYMENT CHANGE (employment, unemployment, part-time to full-time, full-time to part-time)

_____ CHANGE IN EMPLOYMENT STATUS OF EMPLOYEE (Submit detail)

DETAIL: _____

SUBMIT NEW ENROLLMENT FORM OR INCLUDE NEW PER PAY DEDUCTION:

_____ HEALTH INSURANCE

_____ DENTAL INSURANCE

_____ HEALTH EXPENSE

_____ DEPENDENT CARE

_____ ADOPTION ASSISTANCE

_____ OTHER (Any other benefit available to you)

_____ (PLEASE SPECIFY)

PAY DATE CHANGE WILL BE EFFECTIVE: _____

(If termination, pay date deductions will stop)

RECEIVED ON AND PROCESSED ON: _____

EMPLOYEE AUTHORIZATION: _____ DATE: _____
