

FLEXIBLE BENEFITS PLAN CHANGE FORM



M.A. SERVICES
 PO Box 587
 PITTSFORD, NY 14534
 585.730.8044 OR 800.836.8100
 FAX: 585.248.2488

EMPLOYEE INFORMATION (Please Print)											
Employer:	Plan Year:										
Employee Name:	Employee SSN: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>										
Address:	City, State, Zip code										

PERSONAL DATA CHANGE (Please Print)
<input type="checkbox"/> Name Change:
(Former Name) _____
<input type="checkbox"/> New Address:

FAMILY STATUS CHANGE (Due to one or more of the following) (Please Print)	
<input type="checkbox"/> Marriage/Divorce	Date: _____
<input type="checkbox"/> Birth/Adoption	Date: _____
<input type="checkbox"/> Death	Date: _____
<input type="checkbox"/> Spouse Employment Change (Employment, Unemployment, part-time to full-time, full-time to part-time)	Detail: _____
<input type="checkbox"/> Change in Employment Status of Employee	Detail: _____

Include New Per Pay Deduction:	New Per – Pay Amount	Pay Date Change will be effective
Health Insurance		
Dental Insurance		
Health Expense		
Dependent Care		
Adoption Assistance		
Other (PBA etc.)		

Employee Authorization: _____ Date: _____

Received & Processed on: _____