Section 125 Change In Status Request Form

Please complete Sections 1 - 4 and return form to your Human Resources Department within thirty (30) days of the change in status event.

In accordance with the IRS Consistency Rule, change to a cafeteria plan election due to a change in status must be consistent with the affect the change in status has on eligibility under the plan. An exception is made for the group term life, accidental death and dismemberment, and long-term disability.

Section 1: About You (All information is required. Please print clearly.)

Employer Name			
Participant Name			Social Security # (last four digits only)
Email Address			Daytime Phone #
Current Election:	Per Pay Period $	Annual Contribution $	Contributions to Date $
Effective Date of Benefit Change		1st Paydate Affected	

Section 2: Explanation of Change in Status Event

PLEASE CHECK THE FOLLOWING THAT APPLIES TO YOUR EXPERIENCE: CHANGE MUST AFFECT ELIGIBILITY FOR COVERAGE
(Note: You may be required to submit appropriate documentation to verify the event.)

- ☐ Change in legal marital status (marriage, divorce, annulment, legal separation, death of spouse)
- ☐ Change in number of federal tax dependents (birth, adoption, placement for adoption, death)
- ☐ Dependent meets or ceases to meet dependent eligibility status
- ☐ Change in employment status of employee, spouse or legal dependent
- ☐ Change in place of residence of an employee, spouse or legal dependent which affects their eligibility*
- ☐ Significant change in employee, spouse or legal dependent's health coverage; due to loss of eligibility of group insurance
- ☐ Change in employee's dependent care provider and/or rates*
- ☐ Change in Spouse's benefit elections due to open enrollment or valid mid-year change that creates a change in eligibility under his/her employer's benefit plan
- ☐ Other: (i.e., special requirements relating to Family and Medical Leave Act (FMLA), HIPAA Special Enrollment Rights, COBRA Entitlement, gain or loss of Medicaid or Medicare)

**Does not apply to Medical Care Reimbursement*

Section 3: Election Change (Complete the section(s) that will change due to your status change event.)

Type	Pay Period Amount	X	Remaining Pay Periods	+	To Date Contributions	=	New Annual Contribution
Medical Care Reimbursement	$	X		+	$	=	$
Dependent Care Reimbursement	$	X		+	$	=	$
Group Health Premiums: New Premium Amount			$				

Section 4: Authorization

I have read and fully understand the regulations to change my election. I understand that this Change in Status Form must be completed within (30) days of the change in status event and the election change I have requested is consistent with my change in status event. I understand retroactive election changes are not allowed and that my election change will be effective on the later of the date of the change in status or on the date I request the election change. I certify that the above information is true and correct and agree to provide any necessary third-party documentation to verify the change in status event. I understand that I may be required to provide the appropriate documentation for any of the changes indicated above. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have (60) days to appeal the decision.

Participant Signature	**Date**
Employer Authorization Signature	**Date**

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Once completed and approved by Human Resources, submit completed form to:
Goldleaf Partners via fax at 844.756.9743 or email to benefits@goldleafpartners.com

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