

# EMPLOYEE CAFETERIA PLAN CHANGE/TERMINATION REPORT

|                                |                     |
|--------------------------------|---------------------|
| EMPLOYER NAME                  | GROUP NO.           |
| EMPLOYEE LAST NAME, FIRST, MI. | SOCIAL SECURITY NO. |
| STREET ADDRESS, CITY & STATE   | ZIP CODE            |

## TERMINATION

\_\_\_\_\_ Terminate all cafeteria plan benefits effective \_\_\_\_\_ (date)

## EMPLOYEE CHANGE OF STATUS

I wish to amend my Cafeteria Plan election because the following change has occurred in my family status:

\_\_\_\_\_ Marriage \_\_\_\_\_ Divorce \_\_\_\_\_ Date: \_\_\_\_\_

Change my name from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Birth \_\_\_\_\_ Adoption \_\_\_\_\_ of a child: Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Death of a spouse or dependent: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Termination or Commencement of employment of Spouse: Date: \_\_\_\_\_

Explain: \_\_\_\_\_

Switching from part-time to full-time employment status (or from full-time to part-time)

you or your spouse. Date: \_\_\_\_\_

Explain: \_\_\_\_\_

Taking an unpaid leave of absence by you or your spouse. Date: \_\_\_\_\_

Explain: \_\_\_\_\_

Significant change in health coverage attributable to your spouse's employment:

Date: \_\_\_\_\_

Explain: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_  
Signature and Date

## EMPLOYEE CHANGE OF NAME or ADDRESS

|                      |                 |             |
|----------------------|-----------------|-------------|
| _____ Name Change    | From:           | To:         |
| _____ Address Change | Street Address: | City, State |
|                      |                 | Zip Code    |

Prior premium deduction \_\_\_\_\_

New Premium deduction \_\_\_\_\_

Prior unreimbursed medical deduction \_\_\_\_\_

New unreimbursed medical deduction \_\_\_\_\_

Prior dependent care deduction \_\_\_\_\_

New dependent care deduction \_\_\_\_\_