Cafeteria Plan Change of Status Form

(Please complete this form and return it to your Human Resource Department)

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

Personal Information	Company Name	Social Security Number
	Employee Name (First Name, Last Name)	Current Date
	Street Address, City, State, Zip	Date of Event/Termination

Qualifying Event

☐ **Change of Status**
i.e. Marriage, Divorce, Death, Legal Separation, Birth, Adoption, No Longer Dependent, Employment Change, Spousal Employment Change, etc.

List all Dependents (including Spouse):

Full Name	Date of Birth	Relationship	Reason for Change of Status

☐ **Change Cost or Provider** – Dependent Care
i.e. Change of Day Care Provider, Cost Increases or Decreases

☐ **Termination of Employment**

Change of Benefit

The payday that the new deduction begins: _____

	Prior Annual Election Amount	New Annual Election Amount	Frequency of Withholding (weekly, semi-monthly, etc.)
Health Care Expense			
Day Care Expense			

Date of last payroll deduction (if termination of employment): _____

Employee Signature	Employee Signature	Date
	Company Representative Signature	Date

Welfare-524 (07/2011)

Please return to your Human Resource Department