

SECTION 125 FLEXIBLE BENEFIT PLAN CHANGE OF STATUS FORM

Employer			
Employee's Last Name	First Name	SS#	
Employee's Address	City	State	Zip

MEMBER PROFILE CHANGES

- MEMBER NAME CHANGE ONLY
 MEMBER ADDRESS CHANGE ONLY
 MEMBER DIRECT DEPOSIT CHANGE (Fill out required information below)

<p style="text-align: center;">Direct Deposit</p> <p>Reimbursements are electronically deposited into your bank account. A Copy of/ or Voided Check Must be attached. Deposit slips are not accepted.</p>	<input type="checkbox"/> Begin deposits <input type="checkbox"/> Cancel deposits and issue manual checks <input type="checkbox"/> Continue deposits using new account information	<input type="checkbox"/> Checking Routing # _____ <input type="checkbox"/> Savings Account # _____ Bank Name _____
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ELECTION CHANGE CODES

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| <input type="checkbox"/> MEDICAL INSURANCE PLAN ANNIVERSARY CHANGES
<input type="checkbox"/> MARRIAGE
<input type="checkbox"/> BIRTH OR ADOPTION OF A CHILD
<input type="checkbox"/> EMPLOYMENT OF SPOUSE
<input type="checkbox"/> AWAY ON LEAVE OF ABSENCE Date: __/__/__
<input type="checkbox"/> Continue participation, member to make up pre tax contributions upon return from leave
<input type="checkbox"/> Continue participation, member to continue contributions post tax
<input type="checkbox"/> Stop participation

<input type="checkbox"/> FAMILY DEPENDENT'S STATUS CHANGE
<input type="checkbox"/> CHANGE IN PAY STATUS
<input type="checkbox"/> VENDOR RATE CHANGE (Applies to Insurance Premiums, and Day Care Providers) | <input type="checkbox"/> TERMINATE EMPLOYMENT
<input type="checkbox"/> DIVORCE
<input type="checkbox"/> DEATH OF SPOUSE OR CHILD
<input type="checkbox"/> TERMINATION OF SPOUSE'S EMPLOYMENT
<input type="checkbox"/> BACK FROM LEAVE OF ABSENCE Date: __/__/__

<input type="checkbox"/> CHANGE FROM Full-Time TO Part-Time STATUS
<input type="checkbox"/> CHANGE IN SPOUSE'S PAY STATUS
<input type="checkbox"/> CHANGE IN SPOUSE'S CAFETERIA PLAN |
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EXPENSE TYPE (Please Check)	NEW DEDUCTION AMOUNT <i>Per Pay Period</i>	or DELETE
HEALTH INSURANCE PREMIUMS	\$ _____	\$ _____
HEALTH SAVINGS ACCOUNT DEDUCTIONS TO BANK	\$ _____	\$ _____
DEPENDANT DAYCARE EXPENSES	\$ _____	\$ _____
UNREIMBURSED MEDICAL EXPENSES	\$ _____	\$ _____
LIMITED MEDICAL EXPENSES <i>VISION and/or DENTAL ONLY</i>	\$ _____	\$ _____

Annual Elections can only be changed upon completion and submission of this form within 30 days of status change.

I certify that effective __/__/__, I had a change in family and/or employment status as noted above and request that changes in my benefits be made as indicated. Change to be effective on Pay Date __/__/__.

Signature

Date

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