



FLEX PLAN
The Flexible Benefits Plan
Change in Status
Election Change Form

Instructions: Request for mid-year election change in the event of a change in status as noted below.

Participant Name: Soc. Sec. No:

Home Address: Number/Street City State Zip Code

Employer Name:

I request the following change(s) in my benefit election(s) and salary redirection which are consistent with the change in status noted below:

Table with 4 columns: I Benefits, Change Annual Election FROM, Change Annual Election TO. Rows include Health Insurance Premium, Dental Insurance Premium, Vision Insurance Premium, Unreimbursed Medical FLEX Spending Account(UMA), Dependent Day Care FLEX Spending Account (DC), Premium Expense FLEX Spending Account (PE), and Other (specify).

- II Type of Change:
Marital Status (marriage, divorce, separation, annulment, death of spouse)
Number of Dependents (birth, death, adoption or placement for adoption)
Employment Status (spouse/dependent termination, strike, leave of absence, worksite, eligibility for benefits)
Residence (changes which affect eligibility or access to service provider)
Gain/Loss of Eligibility for Medicare/Medicaid
Cost of Coverage Change (Not Applicable to UMA. Not Applicable to DC, if provider is a relative.)
Coverage Change (Not Applicable to UMA.)

III Date of Occurrence:

IV Consistency Requirement:
You must give specifics of change indicating how requested change in election is consistent with change in status event.

Three horizontal lines for providing details.

Participant Signature: date

Employer Signature: date

WHERE TO SEND COMPLETED FORM:
•original - File with Employer
•copy - PGP, P.O. Box 15136, Albany, N.Y. 12212-5136 (FAX 518 641-0325)