Flexible Benefit Plan Change in Family Status and Employee Termination Form

Employer:

Employee Information

Employee Name _____ Social Security Number _____ Plan Year End _____

Employee Address _____ City _____ State _____ Zip _____

Certification of Family Status Change

If employee has terminated, please fill in the contributions to date.

As a Participant in the Cafeteria Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in family status. I understand that the change in my benefit election must be necessitated by and consistent with the change in family status and that the change must be acceptable under the regulations issued by the Department of Treasury.

I certify that I have incurred the following change in family status:

- [ ] Marriage
- [ ] Divorce, Legal Separation or annulment
- [ ] Birth or adoption of a child
- [ ] Death of my spouse and/or dependent
- [ ] Termination of employment by employee
- [ ] Termination or commencement of employment by my spouse or dependent
- [ ] My spouse or I have taken an unpaid leave of absence
- [ ] Switching from part-time to full-time (or vice-versa) employment on the part of me, my spouse or dependent
- [ ] A significant change in my family's health coverage attributable to my spouse's employment
- [ ] Dependent ceases to satisfy the requirements for unmarried dependents due to attainment of age, student status or any similar circumstances as provided under the accident or health plan under which the employee receives coverage
- [ ] A change in the place of residence or worksite of the employee, spouse or dependent
- [ ] Other (briefly explain the change in family status in the space provided below)

_____

This is to certify that on_____ (Date of Event), I incurred the employment/family status change(s) checked above, and therefore wish to change my prior benefit elections as indicated below.

Participant's Signature _____ Date _____

Contributions to Date of Change and New Elections

- [ ] Health Reimbursement Plan
  Contributions to date (Employee deductions and Employer contributions): $_____
  The NEW amount of compensation redirection will be (for terminated employees this should equal the number above):
  $_____ Per Pay Period; Totaling $_____ for the Plan Year

- [ ] Dependent Care Reimbursement Plan
  Contributions to date (Employee deductions and Employer contributions): $_____
  The NEW amount of compensation redirection will be (for terminated employees this should equal the number above):
  $_____ Per Pay Period; Totaling $_____ for the Plan Year

Participant's Signature _____ Date _____

CLEAR Button

WARNING: When using public computers at a library, school, etc., be sure to click on the "Clear Form" button after completing and printing your form. Even though you log-off or close the Internet site, the next person may be able to access the prior user's data.

Midwest Group Benefits, Inc.
PO Box 408
Decorah, IA 52101

Other Terms and Conditions

I understand that:

Medical reimbursements will be available only for "qualifying medical care expenses." Generally, "qualifying medical care expenses are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or social security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

I cannot seek reimbursement from the Health Reimbursement Plan for a medical expense that I intend to take as a deduction on my tax return.

Dependent care reimbursements will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan Document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or social security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

I will only be reimbursed for dependent care expense for amounts up to the balance in my dependent care reimbursement account at the time of my request.

I cannot claim a dependent care tax credit on amounts I receive as dependent care reimbursements under the Dependent Care Reimbursement Plan.

I cannot change or revoke any of my elections or this Compensation Reduction Agreement at any time during the plan year unless the Plan allows modifications due to a change in family status as defined in the Summary Plan Description.

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this Agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this Agreement shall be in addition to any reductions under other agreements or benefits programs maintained by my Employer.

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected not to participate for the following year.

This agreement is subject to the terms of the Employer's cafeteria plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.