



**CITY OF AUBURN HILLS
CHANGE IN FAMILY STATUS ELECTION FORM
SECTION 125 CAFETERIA PLAN**

Participant's Name _____ Soc. Sec. _____

For Plan Year Beginning _____ Through _____

To: isolved Benefit Services

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 the change in my benefit election must be necessitated by and consistent with the change in family status and the change must be acceptable under the Regulation issued by the Department of Treasury of the United States of America. I certify I have necessitated the following change in family status:

EFFECTIVE DATE OF CHANGE _____ **1ST PAY DEDUCTION DATE** _____

_____ Birth/adoption of child(ren)

_____ Death of spouse/dependent

_____ Termination/commencement of employment by spouse

_____ Switching from part-time to full-time (or vice-versa) employment for my spouse or me.

_____ I or my spouse has taken an unpaid leave of absence.

_____ A significant change in family's health coverage attributed to my spouses employment.

_____ Address – Street _____ City _____ State _____ Zip _____

_____ Other _____

TERMINATION

Date of termination _____ **Last pay deduction date** _____

I hereby consent to the use of my personally identifiable information, and or my dependent(s)' information, which I have voluntarily provided in this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependent(s)' behalf, for the sole use of providing benefits, services, or any information I have requested.

Employee's

Signature _____ Date _____

Accepted and agreed to by _____

Administrator

By: _____ Date _____