BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

Section 125 Cafeteria Plan
Change in Status/Termination Election Form

The following must be completed when an eligible change in status occurs:

Employer name _____
Employee name _____
Social Security Number _____ Phone _____
Employee address _____
Effective date of change _____ If terminating, date of last deduction _____

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

Part 1

I certify the following change in status has occurred:

A. Change in Marital Status

- ❑ Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment.

B. Change in Number of Tax Dependents

- ❑ Change in the number of tax dependents including birth, adoption, placement for adoption or death of a dependent.

C. Changes in Spouse or Dependent's Eligibility Under an Employer's Plan

- ❑ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.
- ❑ Judgment, decree or order including the imposition of a Qualified Medical Child Support Order.
- ❑ Gain or loss of Medicaid or Medicare entitlement.
- ❑ Entitlement to COBRA.
- ❑ Special requirements relating to the Family and Medical Leave Act (FMLA).

D. Change in Employment Status that Changes Eligibility Status

- ❑ Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.
- ❑ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.
- ❑ Change in eligibility due to change in residency of the employee, spouse or dependent.

E. Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only)

- ❑ Significant cost increase in your or your dependent's coverage.
- ❑ Significant curtailment of your or your dependent's coverage.
- ❑ Addition or elimination of benefit package option under your or your dependent's employer's plan.
- ❑ Change in coverage or open enrollment of spouse or dependent under other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.
- ❑ Dependent care provider is replaced by another.

Part 2

Please change my election(s) as follows:

Premium Savings Account

Change **insurance premiums** to $_____per pay period.

Health Care Expense Account

Change my annual election for my **Health Care Expense Account** from $_____ to $_____. My new per pay period election will be $_____ effective with the _____ payroll.

Dependent Care Assistance Program

Change my annual election for my **Dependent Care Assistance Program** from $_____ to $_____. My new per pay period election will be $_____ effective with the _____ payroll.

_____ _____
Employee signature Employer Representative Signature

_____ _____
Date Date

P.O. Box 98025 ❖ Baton Rouge, Louisiana 70898 ❖ 225-298-3105 ❖ Fax 225-297-2665 ❖ www.ezflexplan.com/bcbsla

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