STATUS CHANGE AMENDMENT

(Form must be signed by Employer.)

Employer: _____

Plan Year: _____ to _____

Employee Name: _____

Social Security Number: _______________

I hereby request to revise my elections due to a change in my status and make a new election for the remainder of the current plan year. I understand that my deduction and my status will not be retroactive and the status change does not go into effect until approved by my employer.

Please describe below the change in status and explain why the requested change is consistent with your status change event. An election change is consistent only if the election change is necessary or appropriate as a result of the status change event:

_____

_____

Note: You may be required to submit appropriate documentation to verify the event.

Date Status Change Event Occurred: _____

Payroll Date to Start: _____

Deduction

M - Monthly = 12
S - Semi Monthly = 24
Bi - Bi Weekly = 26
W - Weekly = 52

The revised election(s) I wish to make under the Cafeteria Plan are as listed below:

Payroll Reduction Items	**Revised Amount** (Per Deduction)
_____	_____
_____	_____
_____	_____

Flexible Spending Accounts	(Per Deduction)	**Plan Year Amount**
Dependent Care Spending Accounts	_____	
Unreimbursed Medical Spending Accounts	_____	_____

I understand that my election change must be made within 90 days of the change in status event, and the election change I have requested must be consistent with the change in status event. I understand that the actual change, will be effective the date the status change form is signed and submitted. I certify that the above information is true and correct, and agree to provide any necessary third-party documentation to verify the change in status event. This hereby amends any previous salary election form.

Please sign only one line.

YES I **WISH TO PARTICIPATE -** I agree that my salary will be reduced by the amount(s) shown for the benefit option(s) I have elected under the Cafeteria Plan.

EMPLOYEE SIGNATURE: _____ DATE: _____

NO I **DO NOT WISH to Participate** - Due to the above status change, I hereby DECLINE.

EMPLOYEE SIGNATURE: _____ DATE: _____

APPROVAL
EMPLOYER SIGNATURE: _____ DATE: _____

Southern Administrators and Benefit Consultants, Inc.
P.O. Box 2449 • Madison, Mississippi 39130-2449 • WWW.SABCFLEX.COM