flexplan
ADMINISTRATORS, INC

Flex Plan
Change Form

Employee Information	
Name:	Change/Termination Date:
Mailing Address:	Date of Birth:
City, State, Zip:	Phone:
First Payroll Date of Change:	SSN:

QUALIFYING EVENT (please circle one)

Voluntary Termination (Final Paycheck) ◯	Voluntary Termination of Spouse ◯
Involuntary Termination (____ / ____ / _____) ◯	Involuntary Termination of Spouse ◯
Marriage ◯	Away on Leave of Absence ◯
Divorce ◯	Back from Leave of Absence ◯
Birth/Adoption of Child ◯	Family Dependent's Status Change ◯
Death of Spouse/Child ◯	Change from Full Time to Part Time ◯
Employment of Spouse ◯	Child/Elder Care Rate Change ◯

OTHER CHANGES

Address Change ◯	Name Change to: ◯ _____
Change in Payroll/Deduction Frequency ◯	Administrative/Clerical Change ◯

PAYROLL CHANGES

Employee Benefit	Provider	Current Payroll Deductions	New Payroll Deductions
FSA Healthcare Expense			
FSA Dependent Care			
Medical Insurance			
Dental Insurance			
Disability Insurance			
401 (k)			
Voluntary Term Life			
Other			

I certify that on the above effective date, I had a change in family and/or employment status as indicated and request that changes in my benefits be made as indicated. Benefit elections not changed above shall remain in effect until the Plan Anniversary Date except in case of another qualifying change. This form must be received by FlexPlan Administrators, Inc. within 30 days of change in status.

EMPLOYEE:

Signed: _____ Date: _____

EMPLOYER:

Signed: _____ Date: _____

FlexPlan Administrators, Inc.
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Phone: 918-524-6350 Fax: 918-524-6335