Change in Status

Employee Benefit Change Form

Employee Name: _____ Date: _____

Employee Address: _____

Social Security Number: _____ Effective Date of Coverage Change: _____

-OR-

Employee ID#: _____ Effective Date of Coverage Termination: _____

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Complete this form when a change in status has occurred which affects your benefit coverage. All changes must be due to and consistent with your specific change in status. Proof of said change must be provided with this form and submitted to the Benefits Department. Benefit coverage cancellations will in most cased be processed in the month they are received and become effective the last day of that same month unless form is received after payroll has processed.

Change in Status/Cancellation under Section 125 Cafeteria Plan (Tax Shelter)

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.

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

Change in Marital Status

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

Change in Number of Dependents

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

Change in Spouse or Dependent's Eligibility under an Employer's Plan

- ☐ Change in dependent status such as child's age, student status, or marital status.
- ☐ Change regarding Qualified Medical Child Support, COBRA, Medicaid or Medicare entitlement, and special requirements relating to FMLA.

Change in Employment Status that Changes Eligibility Status

- ☐ Change of employment status for spouse or dependent.
- ☐ Change in work schedule, such as change from full-time to part-time or commencement/return from an unpaid leave of absence.
- ☐ Change due to relocation of the employee, spouse or dependent.

Change in Cost or Coverage (applicable for health insurance elections only)

- ☐ Significant cost increase or reduction in current coverage within the last 30 days (Must provide proof of significant cost increase or change in coverage).
- ☐ Change in coverage or open enrollment of spouse or dependent under other employer's plan.

Change in Status/Cancellation of Coverage not affected by Tax Shelter

I understand that during the plan year, I can only modify or cancel benefit coverage for which I previously elected to waive pre-tax benefits. Any additional coverage will be available during the open enrollment period. Please contact the Benefits Department with any questions. All insurance cancellations are effective the last day of the month in which the completed forms are returned to the Employee Benefits Department.

All cancellations and changes must be completed within 60 days of the qualifying event.

I wish to change or cancel the following benefits (check all that apply):

- ☐ **Health Insurance – State of Mississippi**
  - **A completed enrollment/change form is required. Contact Employee Benefits Department**
- ☐ **Life Insurance – State of Mississippi**
  - **A completed enrollment/change form is required. Contact Employee Benefits Department**

- ☐ **Delta Dental**
  - **Dental Plan**
    - **Policy Cancellation _____ Effective Date: _____**
    - **Change Coverage:**
      - **Spouse: Drop___ Add___**
      - **Children: Drop___ Add___**

- ☐ **EyeMed Vision**
  - **Vision Plan**
    - **Policy Cancellation _____ Effective Date: _____**
    - **Change Coverage:**
      - **Spouse: Drop___ Add___**
      - **Children: Drop___ Add___**

- ☐ **American Fidelity**
  - **Cancer** **Policy Cancellation _____ Effective Date: _____**
  - **Disability** **Policy Cancellation _____ Effective Date: _____**
  - **Accident** **Policy Cancellation _____ Effective Date: _____**
  - **Group Critical Illness** **Policy Cancellation _____ Effective Date: _____**
  - **American Fidelity Life** **Policy Cancellation _____ Effective Date: _____**
  - **Hospital Gap** **Policy Cancellation _____ Effective Date: _____**

- ☐ **TelaMed** **Policy Cancellation _____ Effective Date: _____**
- ☐ **Texas Life** **Policy Cancellation _____ Effective Date: _____**
- ☐ **Boston Mutual** **Policy Cancellation_____ Effective Date:_____**
- ☐ **LegalShield - IDShield** **Policy Cancellation_____ Effective Date: _____**

_____ _____

Employee Signature **Date**

Official Use Only

Date form was received in Employee Benefits Department: _____

Date Payroll Deduction(s) were revised in Munis: _____

Date Insurance Provider Notified: _____

_____ _____

Employer's Authorized Representative **Date**