ROWAN COUNTY

CAFETERIA PLAN

STATUS CHANGE FORM

Name (First, Middle, Last)	Social Security Number

Department/Location	Effective Date of Change

I wish to make a change in my Cafeteria Plan Election which is consistent with the following status change (proof of status change may be required). A request must be made within 30 days from the date of the status change event which occurred on _____. Please check the applicable status change event below and attach a brief explanation or supporting documentation.

1) ***Legal Marital Status***
   - ☐ Marriage
   - ☐ Divorce
   - ☐ Legal separation
   - ☐ Annulment
   - ☐ Death of spouse

2) ***Number of Tax Dependents***
   - ☐ Birth
   - ☐ Adoption
   - ☐ Placement for adoption
   - ☐ Legal Guardianship Change
   - ☐ Legal Custody Change
   - ☐ Death of a dependent
   - ☐ Qualified Medical Child Support Order
   - ☐ Judgment, decree, order

3) ***Employment Status That Affects Eligibility***
   - ☐ Termination of spouse's or dependent's employment
   - ☐ Commencement of spouse's or dependent's employment
   - ☐ Begin or return from FMLA leave of absence
   - ☐ Begin or return from unpaid nonFMLA leave of absence
   - ☐ Switch from full-time to part-time
   - ☐ Switch from part-time to full-time
   - ☐ Switch between hourly and salaried
   - ☐ Strike/lockout

4) ***Tax Dependent Gains or Loses Eligibility***
   - ☐ Attainment of age
   - ☐ Marriage
   - ☐ Student status

5) ***Dependent Care Reimbursement Account***
   - ☐ Cost increases (not allowed if provider is a relative)
   - ☐ Cost decreases (not allowed if provider is a relative)
   - ☐ Child turns age 13
   - ☐ Coverage change
   - ☐ Employee changes provider

6) ***Other***
   - ☐ Open enrollment under spouse's employer's group plan on _____.
   - ☐ Change in residence or worksite affecting eligibility
   - ☐ Exhausted COBRA medical coverage (HIPAA)
   - ☐ Medicaid gain or loss
   - ☐ Medicare gain or loss
   - ☐ Significant change in spouse's employer's health coverage
   - ☐ Other (explain on next page)

Employee Signature	Date

Plan Administrator	[ ] Approved [ ] Not Approved

ATTACH NEW INSURANCE AND/OR REIMBURSEMENT ENROLLMENT/ELECTION FORM

EXPLANATION OF STATUS CHANGE EVENT

Please explain below the Status Change event or change in cost or coverage. Also, please explain how the requested change is consistent with the event:

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I understand that I may be required to provide supporting documentation of the Status Change.

_____   _____
Employee Signature   Date