CAPROCK
HEALTH GROUP
A Healthcare Services Organization

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Change of Election/Termination Form

Employee Data: (Required)

Employer Name:	
Employee Name:	
Employee ID or Social Security Number:	

Benefits Being Changed\Terminated: (Required)

Medical	Dental	Life	Flex (Medical)	Flex (Dependent Care)
Other				

Type of Status Change: (Required)

Participants of the benefit plans are entitled to revoke or change benefit elections only under specified circumstances. Elections must be necessitated by and consistent with the change in family status and must be acceptable as specified by the Plan Documents, or in the case of FSAs, the Department of Treasury. Please identify the type of Status Change incurred. This list is not conclusive. Please call Verity National for assistance completing this form.

- Marital Status Change (marriage\divorce)
- Change in number of Tax Dependents (birth\adoption of a child, death of spouse\dependent). List Dependent to be changed.
- Commencement of Benefits (for employee, spouse or dependents)
- Work Schedule Change (full-time to part-time or vice versa which causes loss of eligibility)
- Dependent eligibility change (either satisfying or ceasing to satisfy eligibility requirements)
- Increase or Decrease in Dependent Care Provider's Monthly Fees (when the provider is not a relative of the employee)
- Other : (list) ____
- Termination of Employment (employee, spouse, or dependents)

Date of Status Changed: (Required)

Request for Change of Election must be made within 30 days of the date of Family Status Change. Please identify the exact date of the Status Change, any additional amounts deducted from the final paycheck, and the year to date deductions.

Status Change Date:

Dependent Status Change: Check 'Add' to add a dependent and provide dependent details. Check "Drop" to delete a covered dependent from the plan.

	MEMBER/DEPENDENT NAME (Full Name)	**DATE OF BIRTH** (Child must be full-time student age 19-21.)	**SEX** (Circle One)	**RELATIONSHIP** (spouse, daughter, son, step-son, etc.)	**DEPENDENT SOCIAL SECURITY NO.**
Add Drop			M / F		
Add Drop			M / F		
Add Drop			M / F		
Add Drop			M / F		

Statement of Consistency:

IRS guidelines outline that an election change must be "consistent with and on account of " status change. Please describe why the election change is necessary or appropriate given your status change.
Describe Reason for Change:

Election Change Request:

Medical Expenses	Dependent Care Expenses
New Annual Election :$ _____________ Pay Period Deduction Amount: $ ___________	New Annual Election :$ _____________ Pay Period Deduction Amount: $ ___________
Plan Yr Maximum: Check with your HR Department for your Specific Plan maximum	Calendar Plan Yr Maximum: $5,.000.00 (Set by IRS)
This election is for eligible medical expenses for yourself and/or your spouse\dependents. Insurance premiums **cannot** be counted.	This election is eligible for dependent care expenses (daycare, childcare, or elder care). This election **cannot** be used for medical expenses for your dependents.

Verification:

I understand that my election is made for the entire plan year and is revocable only under certain circumstances specified by law. I certify that the above-qualified Status Change has occurred on the date specified. Further I am requesting a change in my plan election that is consistent with the Status Change indicated above. *Participant signature is not necessary for termination.*

Date:	Participant Signature:
Date:	Employer/HR Signature: