COUNTY OF SANTA ROSA
FLEXIBLE BENEFITS PLAN
FAMILY STATUS CHANGE FORM

Name:____

Address:____

City, State & Zip:__________________________________

Social Security Number:______________________________

As a participant in the Flexible Benefits Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in my family status. I understand 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 family status:

_______Marriage or Divorce

_______Birth, Adoption of a child; Death of my spouse and/or dependent

_______Termination or Commencement of employment by my spouse

_______Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse

_______My spouse or I have taken an unpaid leave of absence

_______A significant change in my family's health coverage attributable to my spouse's employment

_______Other changes permissible by employer____________________________

Effective,________________,I hereby change my election and compensation redirection agreement under the Flexible Benefits Plan with respect to the following benefit elections:

Coverage/Election	Amount	Circle	Correct	Answer
Medical Care Reimbursement	$______	Revoke	Add	Change
Dependent Care Reimbursement	$______	Revoke	Add	Change
Health Insurance	$______	Revoke	Add	Change
Dental Insurance	$______	Revoke	Add	Change
Group-Term Life Insurance	$______	Revoke	Add	Change
Disability Insurance	$______	Revoke	Add	Change
Cancer/Intensive Care Insurance	$______	Revoke	Add	Change
AD&D Insurance	$______	Revoke	Add	Change
Vision Care Insurance	$______	Revoke	Add	Change

____________________________ ________________________

Employee's Signature Date

____________________________ ________________________

Accepted and agreed to by the above Date