City of Lawton
Cafeteria Plan Change Form

I understand that I may not change my Annual Election(s) in the Cafeteria Plan unless I experience a "qualified change in family status" as mandated by the Internal Service Regulations and that I must make a new Annual Election(s) within the time period specified in the plan of a "qualified change in family status" for it to be effective for the remainder of the plan year. I certify that the following "qualified changed in family status" has occurred:

☐ Marriage ☐ Birth or Adoption of a Child ☐ Full-time to Part-time

☐ Divorce ☐ Death of Spouse or Dependent(s) ☐ Part-time to Full-time

☐ Spouse Employment Termination/Commencement ☐ Unpaid Leave of Absence

☐ Change in Spouse's Health Coverage Indicate if: Employee ☐ Spouse ☐

_____
Date of Qualified Change

MEDICAL CARE EXPENSE REIMBURSEMENT ACCOUNT

Due to the "qualified change in family status" as indicated above, I hereby elect to change my annual periodic pre-tax contribution from $ _____ to $ _____ which will not be less than the reimbursable expenses submitted and to be submitted for the portion of the plan year ending prior to the date of change. I further understand that the plan administrator retains the right to make appropriate adjustments to my election and contributions in order to ensure compliance with the intent of the preceding sentence.

DEPENDENT CARE EXPENSE REIMBURSEMENT ACCOUNT

Due to a "qualified change in family status" as indicated above, I hereby elect to change my annual periodic pre-tax contribution from $ _____ to $ _____.

NOTE: NEW ANNUAL ELECTION(S) DUE TO A "QUALIFIED CHANGE IN FAMILY STATUS" WILL BE EFFECTIVE AS SOON AS ADMINISTRATIVELY POSSIBLE.

Employee Signature:	Date:

Print Name:	Employee No:

This election change form was received by me on behalf of the employer on the date indicated below:

Authorized Signature:	Date: