

## REVISION OF BENEFIT ELECTION FORM

Employer: \_\_\_\_\_ Date: \_\_\_\_\_

Employee: \_\_\_\_\_ SSN: \_\_\_\_\_

### Reason for Change in family Status

Reason (must be indicated)	Date of Family Status Change
Birth/Adoption	____/____/____
Death	____/____/____
Marriage/Divorce	____/____/____
Change in Employment Status of Spouse	____/____/____
Change in Dep Care Due to:	____/____/____

\_\_\_\_\_

### Revise My Election to the Following

Effective \_\_\_\_/\_\_\_\_/\_\_\_\_, change my election agreement to the following. I realize that the change must be reasonable and consistent with the family status change. In addition, the change must be in accordance with IRS Section 125 regulations.

	From	To
Term Life	\$ _____ Per month	\$ _____ Per month
Disability	\$ _____ Per month	\$ _____ Per month
Dental	\$ _____ Per month	\$ _____ Per month
Vision	\$ _____ Per month	\$ _____ Per month
Unreimbursed medical	\$ _____ Per month	\$ _____ Per month
Dependent Care	\$ _____ Per month	\$ _____ Per month
Health Ins.	\$ _____ Per month	\$ _____ Per month
Misc.	\$ _____ Per month	\$ _____ Per month

My benefit elections shall remain in the effect except for the changes listed above. This form must be completed and mailed to OFG Financial Services within 30 days of the family status change. If not received by that date, the change will not be considered valid. I understand that the benefit change requested must be necessary or appropriate as a result of the family status change indicated.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date