CAPROCK
HEALTHPLANS
A Division of Caprock Health Group

125 Cafeteria Plan Change Form

Employer Name: **San Patricio County**

Employee Name: _____Last 4-Digits of SS#:_____

Address:_____City:_____Zip:_____

Reason for Change:

□Spouse Employment Change □Birth or Adoption of Child □Divorce

□Marriage □Termination of Employment □Death of Dependent

□Disability □Retirement □Leave of Absence (LOA)

□Return from LOA □Death of Participant □Other_____

Date of Change:_____

Effect of Change on Payroll Deductions / Annual Election:

Type of Deduction:	Current Deduction	New Deduction	Payroll Date Change is Effective
□**Group Medical**			
□**Dental**			
□**Vision**			
□**Medical/Dental Flexible Spending Account (FSA)**			
□**Dependent Care FSA**			
□**Other**			

Agreement:

1. If I am changing my Medical/Dental Flexible Spending Account deduction, I will have a new annual election amount and this entire amount will be eligible for my use for covered expenses at any time during the year. If I terminate employment no expenses incurred after my termination will be covered. My employer has agreed to this change.
2. I have reviewed the list of eligible changes in the plan document and believe that I qualify for a change in my election amount, as indicated above.

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date