



NORTH EAST ISD CAFETERIA PLAN CHANGE FORM

Name	Employee ID#
Campus/Location	Pay Frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly
<p>According to the Internal Revenue Code, Section 125, a change or revocation of previous elections under the cafeteria plan cannot be made unless there is a family status change. A completed Application along with supporting documentation of the event must be received within 31 calendar days of the status change.</p> <p>IMPORTANT: If your 31st day falls on a weekend or holiday, your forms must be received in the Risk Management & Employee Benefits Office by the last working day prior to your 31st day.</p>	

I hereby request to change my Election and Compensation Reduction Agreement due to the change in family status indicated below:

DATE of Family Status Change	TYPE OF STATUS CHANGE
/ /	Birth of Child, Legal Adoption, or Change in Custody of Child Name of Child:
/ /	Marriage / Divorce (Please circle one)
/ /	Change or Loss of Employment by Spouse or Dependent (Please circle one) Name:
/ /	Death of Spouse or Child (Please circle one) Name:
/ /	Loss of Coverage
/ /	Change in Eligibility – Medicaid or CHIP (60 day deadline for this event ONLY)
/ /	Leave of Absence/RTW
/ /	Other (please specify) :

ACTION TO BE TAKEN: Step #1		<input type="checkbox"/> ADD	or	<input type="checkbox"/> CANCEL
WHO IS AFFECTED: Step #2		<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD <input type="checkbox"/> FAMILY
WHICH PLANS ARE AFFECTED: (Check all that apply)		<input type="checkbox"/> Medical Plan <input type="checkbox"/> Dental Plan <input type="checkbox"/> FSA	<input type="checkbox"/> Vision Plan <input type="checkbox"/> Cancer Plan <input type="checkbox"/> HSA	

Employee Signature _____

Date _____

OFFICE USE: Change Effective: _____

Approval: _____

RETURN TO: NEISD EMPLOYEE BENEFITS OFFICE
8961 Tesoro Drive, Suite 209 San Antonio, TX 78217
Phone: 210-407-0187 Fax: 210-804-7014