Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
Jackson, MS 39236

Section 125 Change Form

Employer Name: _____

Participant Name: _____ Last 4 Digits of SSN: _____

Reason for Change

☐ **Name Change** (Enter New Name): _____

☐ **Address Change** (Enter New Address): _____

_____

☐ **Termination of Employment** Effective Date of Termination: _____

Date of Last Payroll Deduction: _____

Year-to-Date Contributions:

Medflex: $ _____ Careflex: $ _____

☐ **Family Status Change (Signatures Required)** Payroll Date of Change: _____

I, as the participant, have incurred a family status change of one or more of the following during the current plan year. (Check appropriate box or boxes)

☐ Marriage
☐ Birth
☐ Divorce
☐ Legal Separation
☐ Adoption
☐ Other _____

☐ Death of Spouse or Dependent
☐ Change in Work Status of Spouse
☐ Loss of Dependent Status
☐ Change in Day Care (Dependent Care Account Only)
☐ Start/End Leave of Absence

Election Amount Change

Please change my deduction (per pay period) as follows:

	Current	Revised
Health Premium	$ _____	$ _____
Medflex	$ _____	$ _____
Careflex	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____

Verification Statement: I verify that I have read and understand the information on this page and that it is true and correct to the best of my knowledge. I understand that this information will be submitted to GGA.

_____ _____
Participant Signature *Date*

_____ _____
Accepted by Plan Administrator *Date*