Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
Jackson, MS 39236

SECTION 125 CHANGE FORM

Employer Name: _____

Participant Name: _____ SSN: _____

Reason for Change

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

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

_____

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

Termination Status: Date of Last Payroll Deduction: _____

☐ Voluntary Termination Year-to-Date Contributions:

☐ Involuntary Termination Medical FSA: $ _____ Dep Care FSA: $ _____

☐ Retirement

☐ **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
☐ 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
☐ Other _____

Election Amount Change

Flexible Spending Accounts

	Current	Revised
Medical FSA	$ _____	$ _____
Dep Care FSA	$ _____	$ _____

Other Benefit Premiums

	Current	Revised
Health Premium	$ _____	$ _____
Dental Premium	$ _____	$ _____
Vision Premium	$ _____	$ _____

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*