flexCOMP

Company Name:	
Employee Name:	
Change Date:	

Change Affects:	☐ Self	☐ Spouse	☐ Dependent

Reasons for Change Request (check all that apply)

Family Changes	Event Date	Employment Changes	Event Date
☐ Marriage		☐ Job Termination	
☐ Divorce / Legal Separation		☐ Job Commencement	
☐ Death of Dependent		☐ Change to Full Time	
☐ Birth or Adoption		☐ Change to Part Time	
☐ Court Ordered Dep. Coverage		☐ Leave of Absence	
☐ Other: Please describe below		☐ Other: Please describe below	

Benefit Changes	Event Date	Describe Changes Marked "Other" Below:
☐ Cost Increase		
☐ Benefit Decrease		
☐ Employer Cancellation		
☐ Other: Please describe at right		

I certify that the changes indicated above are true and accurate and I have attached a new benefit elections form and any other necessary documents.

Date _____ Signature _____

For Employer Use	
☐ Approved ☐ Rejected	Effective Date (if approved):
Notes:	
Reviewed By:	Date Reviewed:

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