

OKLAHOMA CONFERENCE THE UNITED METHODIST CHURCH  
CHANGE IN STATUS/TERMINATION OF BENEFITS ELECTION FORM

Name (please print): \_\_\_\_\_

Contact # (personal home or cell phone number): \_\_\_\_\_

Address (forwarding address if applicable):  
\_\_\_\_\_

City

State

Zip

Effective \_\_\_\_\_, I hereby change/terminate my benefit election in the health benefits election agreement with the Oklahoma Conference The United Methodist Church, health insurance/Cafeteria Plan with respect to the following changes in coverage: (Please check all that apply)

	Change	Termination
Health Insurance Coverage	_____	_____
Dental Coverage	_____	_____
Vision Coverage	_____	_____
FSA Medical Reimbursement	_____	_____
FSA Dependent Care Assistance	_____	_____

Please check below the reason for the elected benefit change in status/termination. Benefits may only be changed under the following circumstances and changes must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in status/termination of benefits:

\_\_\_\_\_ Marriage

\_\_\_\_\_ Divorce

\_\_\_\_\_ Birth, adoption of a child

\_\_\_\_\_ Death of my spouse and/or dependent

\_\_\_\_\_ Termination of employed by myself, spouse or dependent

\_\_\_\_\_ Switching from part-time to full-time (or vice-versa) employment by myself or spouse or a reduction or increase of hours.

\_\_\_\_\_ I or my spouse have taken an unpaid Leave of Absence

\_\_\_\_\_ My dependent satisfies or ceases to satisfy the requirements for coverage

\_\_\_\_\_  
Employee's signature

\_\_\_\_\_  
Date