DIVERSIFIED GROUP

Your Solution to Health Benefits

SECTION 125
Salary Reduction Agreement - Change Form Authorization

Group Name: RFMH, Inc. Group No.: DAC274GF Plan Year: 2020

Last Name: _____ M.: ___ First Name: _____

Address: _____ City: _____ ST: ____ Zip: _____

Identification Number: _____ **Phone No.**_____

Reason for change (*indicate one below*):

☐ **Marriage** ☐ **Spouse's change of employment** ☐ **Adoption**

☐ **Divorce** ☐ **Relocation of residence** ☐ **Death**

☐ **Birth** ☐ **Dependent Care coverage change** (either cost or hours)

☐ **Health Plan Change** ☐ **Other**_____

(For special events, a change of election during the Plan year may be allowed in accordance with the regulations and rulings of the Internal Revenue Service)

Date Change Requested: Month: _____Day: _____Year: _____

Effective for Pay Period: Month: _____Day: _____Year: _____

Change my Annual Election (s) to the following:

$_____ per pay period for Health FSA Expenses: to equal $_____ per year

$_____ per pay period for Dependent Care Expenses: to equal $_____ per year

Participant Certification: I certify that the change is legitimate and the above date is accurate.

Participant's Signature: _____ Date: _____

Employer's Signature: _____ Date: _____

Fax form to: 860-295-1296 or 860-295-6579