SECTION 125
Salary Reduction Agreement - Change Form Authorization

Group Name: RFMH, Inc. Group No.: DAC274GF Plan Year: 2021

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