



**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** COVID-19 _____

(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: July **Day:** _____ **Year:** 2020

Effective for Pay Period: Month: August **Day:** 12 **Year:** 2020

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