

**DENTAL PLAN
CHANGE IN FAMILY STATUS**

As a participant in the Dental Plan, I understand that I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in family status.

I understand that the new election must be necessitated by and consistent with the change in family status and the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in family status within 30-days prior to signing this election:

_____ Change in legal marital status (marriage, death of spouse, divorce, legal separation, or annulment).

_____ Number of dependents for federal income tax purposes including birth, adoption, placement for adoption, or death.

_____ Termination or commencement of employment by my spouse.

_____ Reduction or increase in hours of employment by participant, spouse, or dependent.

_____ Change in residence or worksite of the participant, spouse, or dependent impacting the ability to participate in the plan.

_____ Other (briefly explain):

Please provide supporting documentation such as Marriage Certificate, Divorce Decree, Birth/Death Certificate, Proof of Other Insurance Coverage, etc.

I understand that the requested change in the Dental Plan election will not be effective in the current Plan Year unless it is made because of a change in family status. I further understand that the change will be effective at the beginning of the first pay period following completion of this form.

Employee: _____ **SS#:** _____

Date: _____

