MOCafe

MISSOURI STATE EMPLOYEES' CAFETERIA PLAN CHANGE FORM

☐ **Check this box if this is a new address.**

Name (Last, First, MI)	Social Security Number	Agency/Org or University

Street Address	City	State	Zip

Date of Status Change Event	Daytime Phone Number

Change of Status Events: Please select all status change events that have occurred in the last 60 days:

- ☐ Death of spouse/dependent
- ☐ Divorce finalized
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Residence change
- ☐ Employment change of your spouse/dependent
- ☐ New dependent care provider
- ☐ Dependent care rate change
- ☐ Gain/Loss of dependent due to age, military status, marriage, divorce, etc.
- ☐ Gain/Loss of eligibility and coverage under Medicare/Medicaid
- ☐ Court order (health coverage not your responsibility)
- ☐ Court order (requiring health coverage)
- ☐ Begin FMLA (Complete Section C)
- ☐ End FMLA
- ☐ Your employment ends or you retire (Complete Section C)

Section A

	Current Per Paycheck Deduction	New Per Check Deduction	Change on Paycheck Dated (Office Use Only – Leave Blank)
Health Insurance*			
Dental Insurance*			
Vision Insurance*			
Voluntary Products (in total only)			

**** No entry needed if this is a change to an existing rate already pre-tax through SAMII for MCHCP coverage.***

	New Annual Total	New per check amount	Change on Paycheck Dated (Office Use Only – Leave Blank)
Health Care FSA			
Dependent Care FSA			
Administrative Fee	**(Leave Blank)**		

Section C: For Health Care FSA Only: (Complete for FMLA beginning or Term/Retire

Terminating or Retiring (event must be selected above)

☐ 1. I authorize a **lump sum** payoff for Health Care Flexible Spending Account (HCFSA) coverage through December 31st of this year totaling $ _____ on my paycheck dated __ / __ / __, **or**

☐ 2. Please **stop** my HCFSA coverage on the date of the last paycheck I will receive.

FMLA beginning (event must be selected above)

☐ 1. I authorize to **prepay for Health Care Flexible Spending Account (HCFSA) coverage** through __ / __ / __ totaling $ _____ on my paycheck dated __ / __ / __, **or**

☐ 2. I will **pay direct** to MO Cafeteria Plan before each pay day. (Make checks payable to MO Cafeteria Plan.) Coverage is stopped if payment is not received by pay date, **or**

☐ 3. When I **return to work,** I elect to pay a total of $_____ for HCFSA coverage through __ / __ / __ on the paycheck I receive on __ / __ / __. HCFSA coverage is stopped if payment is not received by this pay date, **or**

☐ 4. Please **stop** my HCFSA coverage while I'm on upaid FMLA leave. I understand that, if I want to, I can start my coverage within 60 days of returning to work (only at the same amount per check).

Employee's Signature **Day time phone** **Date**

(Payroll/Personnel Officer may sign form if employee is no longer employed)

Mail to: PO Box 858, Columbia, MO 65205-0858 or Fax to: 1-866-381-9682

12/06

Please Read These Instructions First!

MISSOURI STATE EMPLOYEES' CAFETERIA PLAN
CHANGE FORM INSTRUCTIONS

Before you fill in this form:

- One of the 15 Change of Status Events (see the change form) has to have happened already, and
- The event must have happened within the last 60 days. (If it has been more than 60 days, you cannot change your deduction because of that event. You must have another qualifying event to make a change.
- **Effective Date for Coverage Changes:** coverage changes are not in effect until after the event and after this form is received/approved by the MO Cafeteria Plan office. Please refer to your Plan Summary (available from payroll/personnel or on web site, www.mocafe.com) for specifics on effective dates of changes.

Required Information – Please complete all of the following:

1. Print your name, address, Social Security Number and agency/org number. Your Agency/Org is listed on your paycheck stub as a 3 digit/4 alpha-numeric identifier (Universities use acronym)

2. Enter the date of the status change event

3. Please place a check mark or "X" in the event or events that best describe your reason for changing your election.

4. Complete **Section A** if your event has affected the insurance premiums you will pay under the cafeteria plan. Complete **Section B** if your event has affected your Health Care FSA or your Dependent Care FSA deductions under the cafeteria plan.

5. Complete **Section C** only if you have coverage under the Health Care FSA & only if:
   - you retire;
   - you terminate employment with the State; or
   - you begin FMLA leave

6. Sign the change form.

7. Mail to: **or** Fax, toll-free to:
   Missouri State Employee's Cafeteria Plan **1-866-381-9682**
   PO Box 858
   Columbia, MO 65205-0858

8. Payroll/personnel offices will be copied (if data entry is required) on approved changes for MoDOT, Conservation & the Universities. SAMII changes will be updated for payroll/personnel officers for all deductions for MCHCP Health, MCHCP Dental, MCHCP Vision, the Health Care FSA & Dependent Care FSA and administrative fees.

For Assistance, please contact ASI, the administrator of the Missouri State Employees' Cafeteria Plan:
www.mocafe.com 1-800-659-3035 asi@asiflex.com