Mocafe

MISSOURI STATE EMPLOYEES' CAFETERIA PLAN CHANGE FORM

Dependent care rate change Dependent care rate change End FMLA		Name (I	Last, I	First, MI)	Social Secu	ırity Numbeı	Agency/Or	g or Universit	
Change of Status Events: Please select all status change events that have occurred in the last 60 days: Death of spouse/dependent Gain/Loss of dependent due to age, military status, marriage, divorce, etc. Gain/Loss of displinity and coverage under Medicare/Medicaid Marriage Gain/Loss of displinity and coverage under Medicare/Medicaid Court order (health coverage on to your responsibility) Court order (requiring health coverage) New dependent care provider Gout order (requiring health coverage) Begin FMLA (Complete Section C) Begin FMLA (Complete Section C) Begin FMLA (Complete Section C) Gout order (requiring health coverage) Begin FMLA (Complete Section C) Begin FMLA (Complete Section C) Gout order (requiring health coverage) Begin FMLA (Complete Section C) Begin FMLA (Begin FMLA (Begin FMLA) Begin FMLA (Begin		Street Ad	dress		City	State	e	Zip	
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Dependent Care FSA				New Annual Total	New per ch	eck amount			
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Employee's Signature Day time phone Date		Em	nlove	e's Signature	n	av time nhone		Date	

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

please Read These Instructions Firstl

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
 PO Box 858

 Fax, toll-free to:
 1-866-381-9682

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