REVISION OF BENEFIT ELECTION FORM

Employer _____ Date _____

Employee_____ SSN_____

Reason for Change in Family Status

Reason (must be indicated)	Date of Family Status Change
Birth/Adoption	____/_____/____
Death	____/_____/_____
Marriage/Divorce	____/_____/_____
Change in Employment Status of Spouse	____/_____/_____

Revise My Election to the Following

Effective ____/_____/_____, change my election agreement to the following. I realize that the change must be reasonable and consistent with the family status change. In addition, the change must be in accordance with IRS Section 125 regulations.

	From	**To**
Term Life	$_____ per month	$_____ per month
Disability	$_____ per month	$_____ per month
Dental	$_____ per month	$_____ per month
Vision	$_____ per month	$_____ per month
Unreimbursed Medical	$_____ per month	$_____ per month
Dependent Care	$_____ per month	$_____ per month

My benefit elections shall remain in effect except for the changes listed above. This form must be completed and mailed to OFG Financial Services within 30 days of the family status change. If not received by that date, the change will not be considered valid. I understand that the benefit change requested must be necessary or appropriate as a result of the family status change indicated.

_____ _____

Employee's Signature Date