KABEL BUSINESS SERVICES
A DIVISION OF HK PAYROLL SERVICES (HKP)

CHANGE OF ELECTIONS FORM

1454 30th St., Suite 105, West Des Moines, IA 50266 | Ph. 515-224-9400 or 800-300-9691 | Fax 515-224-9256 | www.kabelbiz.com

Company Name (Employer) _____ **Date** _____

Employee Information

_____ _____ _____
Last Name **First Name** **Middle Initial**

_____ _____
Address **City**

_____ _____ _____
Zip Code **Date of Birth** **Social Security Number**

_____
Email Address

Change Information (Please indicate the reason for the change. Change must be submitted within 30 days of the qualifying event)

Reason for Change: ____ **Marriage** ____ **Divorce** ____ **Legal Separation** ____ **Change in Number of Dependents** ____ **Annulment**

____ **Change in work Status (Termination/ Commencement of employment by the employee, spouse or dependents.)**

____ **Other** **Please explain** _____

Change Effective Date _____ **First Payroll Effective Date** _____

New Amount

Annual amount of Unreimbursed Medical $ _____ (Divided by **Remaining** # of Payroll Periods) _____ = Per Payroll Deduction _____

Annual amount of Dependent Care $ _____ (Divided by **Remaining** # of Payroll Periods) _____ = Per Payroll Deduction _____

Insurance Premium Reimbursement Amount $ _____ (Divided by **Remaining** # of Payroll Periods) _____ = Per Payroll Deduction _____

Employee Signature

Authorization and Acknowledgment: I certify the above information to be true to the best of my knowledge. I understand and agree that changes can only be made with qualifying events and the information I am submitting meets those requirements.

Signature _____ **Date** _____

Employer Signature _____ **Position** _____