



ELECTION CHANGE FORM

PLEASE PRINT OR TYPE

PLAN INFORMATION	
EMPLOYER NAME: _____	PLAN YEAR: _____

EMPLOYEE INFORMATION	
EMPLOYEE NAME _____ <small>LAST FIRST MI</small>	SOCIAL SECURITY NUMBER _____
EMPLOYEE HOME ADDRESS _____	
<small>NUMBER AND STREET</small> _____	<small>CITY STATE ZIP CODE</small> _____

As a participant in the cafeteria plan, you are entitled to revoke a prior benefit election and enter into a new election in the event of certain eligible life events. Please complete the following sections to indicate the election change requested. Election changes generally cannot be retroactive. The change in your benefit election must be necessitated by and consistent with an eligible change in family status/life event and that change must be acceptable under the regulations issued by the Internal Revenue Service and must also meet the requirements established by your Plan Sponsor.

ELECTION CHANGE REQUESTED	
EFFECTIVE DATE OF ELECTION CHANGE ¹ _____	REMAINING NUMBER OF PAY PERIODS _____
<input type="checkbox"/> \$ _____ per pay period (\$ _____ annual) for health care expenses	<input type="checkbox"/> Terminate benefit election in health care FSA
<input type="checkbox"/> \$ _____ per pay period (\$ _____ annual) for dependent care expenses	<input type="checkbox"/> Terminate benefit election in dependent care FSA
<i>(For annual total, times pay period amount by the number of remaining pay periods)</i>	

CHANGE IN ELECTION EVENT(S)																																	
Check applicable box(es) to indicate the Change in Election Event(s) that apply to your situation.																																	
A. CHANGE IN STATUS (applies to Premium Payment, Health FSA, and DCAP Benefits; for Health FSA) <ol style="list-style-type: none"> 1. Change in marital status: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Marriage</td> <td><input type="checkbox"/> Divorce/annulment</td> </tr> <tr> <td><input type="checkbox"/> Legal separation</td> <td><input type="checkbox"/> Death of spouse</td> </tr> </table> 2. Change in number of tax dependents: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Birth</td> <td><input type="checkbox"/> Death of dependent</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Adoption or placement for adoption</td> </tr> </table> 3. Change in employment status that affects eligibility: <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">YOU</td> <td style="text-align: center;">SPOUSE</td> </tr> <tr> <td><input type="checkbox"/> Termination of employment</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Commencement of employment</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Part-time to full-time</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Full-time to part-time</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> </table> 	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce/annulment	<input type="checkbox"/> Legal separation	<input type="checkbox"/> Death of spouse	<input type="checkbox"/> Birth	<input type="checkbox"/> Death of dependent	<input type="checkbox"/> Adoption or placement for adoption			YOU	SPOUSE	<input type="checkbox"/> Termination of employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Commencement of employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Part-time to full-time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Full-time to part-time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____			<ol style="list-style-type: none"> 4. Change in dependent's eligibility under an employer's plan: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Lost eligibility (such as age, student status, marital status)</td> </tr> <tr> <td><input type="checkbox"/> Gained eligibility (such as age, student status, marital status)</td> </tr> </table> 5. Change in residence affecting eligibility for: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> You</td> <td><input type="checkbox"/> Spouse or dependent</td> </tr> </table> B. CHANGE IN DCAP COST/PROVIDER <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Significant cost increase or decrease in cost of coverage</td> </tr> <tr> <td><input type="checkbox"/> Changed dependent care providers</td> </tr> </table> C. OTHER EVENT (See your Summary Plan Description for a list of other events that permit a change in election) (PROVIDE DETAILS) _____ _____ _____	<input type="checkbox"/> Lost eligibility (such as age, student status, marital status)	<input type="checkbox"/> Gained eligibility (such as age, student status, marital status)	<input type="checkbox"/> You	<input type="checkbox"/> Spouse or dependent	<input type="checkbox"/> Significant cost increase or decrease in cost of coverage	<input type="checkbox"/> Changed dependent care providers
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I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with the Plan, and the Plan Sponsor has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or under Medicare/Medicaid, or (b) a judgment, decree or order requires an individual other than me to provide accident or health coverage for my child, I certify that such new, improved or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person.

If my change in election is denied, I understand that I will have to appeal the decision within the timeframe specified in the Summary Plan Description for the Plan. If approved, I hereby elect the change(s) noted and attest that the change is made on account of and is consistent with the change in election event.

PARTICIPANT'S SIGNATURE X	DATE
HR's SIGNATURE X	DATE

SERVICED BY MGIS

1 In no event may the termination/new election be effective prior to the first day of the month beginning after this Form is completed and returned to the Administrator, unless a new dependent is being added to medical coverage pursuant to HIPAA Special Enrollment rights, in which case the new election may be consistent with the new medical insurance election, as applicable.