Flexible Benefits Plan

Change in Election

Employee Name: _____ SS#: _____
Street Address 1: _____ Date of Status Change: _____
Street Address 2: _____ Effective Payroll Date: _____
City, State, Zip: _____ Employer: _____

Change Requested: I wish to revoke my existing election under the Flexible Benefits Plan for the following coverage(s); however, my prior election for all other coverage(s) remains in effect:

☐ Premium Conversion (PC) - ☐ Health ☐ Vision ☐ _____
☐ Dental ☐ Term Life ☐ _____
☐ Health Care Flexible Spending Account (HCFSA)
☐ Dependent Care Flexible Spending Account (DCFSA)
☐ Adoption Assistance Flexible Spending Account (AAFSA)
☐ Health Savings Account (HSA)

Change-in-Family-Status Event: A change in election may not be retroactive and must be consistent with a "change-in-family-status" event. Changes in marital status, employment, residence, dependents or dependent eligibility apply to PC, HCFSA and DCFSA. With respect to HCFSA, you may seek to increase or cancel, but not reduce coverage. Changes in dependent care costs or providers apply only to DCFSA. You may increase, decrease, begin or cancel you HSA election prospectively at the beginning of any month.

☐ Change in Marital Status - ☐ Marriage ☐ Divorce / Annulment ☐ Legal Separation ☐ Death of Spouse
☐ Change in Residence - ☐ You ☐ Spouse ☐ Dependent
☐ Change in Dependents - ☐ Birth ☐ Adoption / Placement for Adoption ☐ Death of Dependent
☐ Change in Dependent Eligibility - due to age, student status, marital status
☐ Lost eligibility ☐ Gained eligibility
☐ Change in Dependent Care Cost / Provider
☐ Significant increase / decrease in cost ☐ Change in dependent care service provider
☐ Change in Employment
☐ Termination - ☐ You ☐ Spouse ☐ Dependent: _____
☐ Commencement - ☐ You ☐ Spouse ☐ Dependent: _____
☐ Part-time to Full-time - ☐ You ☐ Spouse ☐ Dependent: _____
☐ Full-time to Part-time - ☐ You ☐ Spouse ☐ Dependent: _____

New Election:	Current Annual Election	Current Per Pay	New Annual Election	New Per Pay
☐ PC:				
_____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____
☐ HCFSA:	$ _____	$ _____	$ _____	$ _____
☐ DCFSA:	$ _____	$ _____	$ _____	$ _____
☐ AAFSA:	$ _____	$ _____	$ _____	$ _____
☐ HSA:	$ _____	$ _____	$ _____	$ _____

I understand that: I may be required to provide appropriate evidence for any change indicated above; status and participation changes must comply with the Plan and the Administrator has sole discretion to make the determination; if I am requesting to cancel or reduce coverage because (a) I or my family member has become eligible for new/improved coverage under an employer's plan or under Medicare/Medicaid or (b) a judgment, decree or order requires someone other than me to provide accident or health coverage for my child, I certify that such new, improved or court-ordered coverage has been or is in the process of being obtained; if my request is denied, I may appeal the decision within the time frame specified in the Summary Plan Description; and, if approved, I attest the change is made on account of and is consistent with the "change-in-family-status" event.

Date: _____ _____
Employee Signature

Accepted and Agreed to on behalf of the Employer by _____ on _____.