



# Flexible Benefits Plan Change in Election/Salary Reduction Agreement

Today's Date: \_\_\_\_\_

**Important: You must complete sections 1 and/or 2 AND sections 3 and 4 of this form.**  
*(Check all applicable boxes)*

IDENTIFYING INFORMATION	
Name: _____	Employee Number: _____

SECTION 1. EXISTING ELECTION
<input type="checkbox"/> <b>REVOCATION OF AN EXISTING ELECTION</b> <i>(See Section 2 if also making a new election.)</i> Effective _____, I wish to <b>REVOKE</b> my existing election under the Flexible Benefits Plan:
<b>Type of Coverage(s) Being Revoked:</b> <b>Health/Dental Insurance Coverage Premium</b> <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Spouse Only <input type="checkbox"/> Dependent(s) Only _____ <input type="checkbox"/> <b>Medical Reimbursement Account</b> <input type="checkbox"/> <b>Dependent Care Reimbursement Account</b>

SECTION 2. NEW ELECTION/CHANGE EXISTING ELECTION
<input type="checkbox"/> <b>NEW ELECTION</b> <input type="checkbox"/> <b>CHANGE EXISTING ELECTION</b> Effective _____, I wish to make the following election(s) under the Flexible Benefits Plan. <i>You may be required to complete additional forms or provide additional information, as may be required by any underlying plan(s); e.g. additional enrollment forms for medical or dental coverage.</i>
<b>Type of Coverage(s) Being Elected or Changed:</b> <b>Health/Dental Insurance Coverage Premium</b> <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent(s) _____ <input type="checkbox"/> <b>Medical Reimbursement Account</b> \$ _____ <i>(Annual election cannot exceed \$5,000)</i> <input type="checkbox"/> <b>Dependent Care Reimbursement Account</b> \$ _____ <i>(Annual election cannot exceed \$5,000)</i>

**SECTION 3. THE CHANGE IN ELECTION EVENT(S) ON WHICH MY REQUEST IS BASED IS/ARE:**

*Check Applicable Box(es) to indicate the Change in Election Event(s) that apply to your situation. Election changes generally cannot be retroactive, and must be consistent with the Change in Election Event(s) described in this section.*

**A. FMLA Leave** (Medical insurance and Health FSA premiums to be paid as follows):

<input type="checkbox"/> After-tax, by sending in payments during leave	<input type="checkbox"/> Pre-tax, by sending in payments during leave
<input type="checkbox"/> Pre-tax, by prepayment	<input type="checkbox"/> After-tax, by prepayment
<input type="checkbox"/> Other (as agreed with the college)	

**B. Changes in Status** (applies to Premium Payment, Dependent Care and Health FSA Benefits)

**1. Change in Marital Status**

<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Legal separation	<input type="checkbox"/> Death of spouse
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**2. Change in Number of Tax Dependents**

<input type="checkbox"/> Birth	<input type="checkbox"/> Adoption or placement for adoption	<input type="checkbox"/> Death of Dependent
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**3. Change in Employment Status That Affects Eligibility**

	You	Your Spouse or Dependent
Termination of employment	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of employment	<input type="checkbox"/>	<input type="checkbox"/>
Benefit-eligible to non-benefit eligible	<input type="checkbox"/>	<input type="checkbox"/>
Non-benefit eligible to benefit-eligible	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of unpaid leave of absence	<input type="checkbox"/>	<input type="checkbox"/>
Return from unpaid leave of absence	<input type="checkbox"/>	<input type="checkbox"/>
Other (salaried to hourly, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. Change in Dependent's Eligibility Under an Employer's Plan**

<input type="checkbox"/> Lost eligibility (such as age, student status, marital status)
<input type="checkbox"/> Gained eligibility (such as age, student status, marital status)

**5. Change in Residence Affecting Eligibility**

You	<input type="checkbox"/>
Your Spouse or Dependent	<input type="checkbox"/>

**C. Special Enrollment Rights Under HIPAA** (applies to Health Coverage Premium Payment Benefit only)

Loss of other group health plan coverage	<input type="checkbox"/>
Acquired new Spouse or Dependent (birth, marriage, adoption, placement for adoption)	<input type="checkbox"/>

**D. Certain Judgments, Decrees and Orders** (applies to Health and Dental Coverage Premium Payment and Health FSA only)

Order resulting from divorce, legal separation, annulment, or change in custody requiring coverage for Dependent	<input type="checkbox"/>
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**E. Medicare or Medicaid** (applies to Health Coverage Premium Payment and Health FSA Benefits only)

Became eligible for Medicare or Medicaid	<input type="checkbox"/>
Lost eligibility for Medicare or Medicaid	<input type="checkbox"/>

**F. Change in Dependent Care Cost**

Significant cost increase	<input type="checkbox"/>
Significant cost decrease	<input type="checkbox"/>

**G. Change in Coverage** (applies to Health and Dental Premium Payment and Dependent Care FSA Benefits only)

- Changed dependent care providers
- Loss of group health coverage under plan of governmental or educational institution (applies to Health and Dental Premiums only)
- Change in coverage under another employer's plan

**SECTION 4. CERTIFICATION**

*Explain below how the election change(s) that you wish to make is/are consistent with the change in election event(s) that you checked in Section 3. You must explain why your requested change is necessary or appropriate as a result of the event you checked in Section 3. The Plan has final discretion to determine whether the consistency requirement has been satisfied.*

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**Other Group Coverage:** If I am dropping coverage for myself, my spouse and/or Dependents because of coverage for such person(s) being added under another group plan, I hereby certify that such person(s) have actually obtained that other group coverage.

**Documentation:** 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 has sole discretion to make this determination. I further understand that for my requested changes to take effect, the changes must be permitted under the terms of any applicable underlying plan or policy.

**Other Forms:** I understand that the requested change may require that I complete other forms or provide additional information, as may be required by any underlying plan(s); e.g. additional enrollment forms for medical or dental coverage.

**If Approved, I hereby elect the change(s) indicated on the attached Election Form/Salary Reduction Agreement and attest that the change is made on account of and is consistent with the Change in Election Event.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

*Accepted and agreed to:*

\_\_\_\_\_  
Plan Administrator's Signature

\_\_\_\_\_  
Date