SECTION 125 PLAN CHANGE OF STATUS FORM

Complete this form when a change of status occurs which affects your Insurance Premium Account, Medical or Dependent Care Reimbursement Account elections. All changes must be due to and consistent with the change in status.

Company Name: _____

Employee Name: _____

Social Security Number: _____

Employee Address: _____

Actual Event Date: _____

Effective Date of Change: _____
(Must be the same day the form is signed and dated by the Employer Representative below.)
Termination Date: _____ End of Coverage Date: _____ Last Pay Date: _____

As a participant in the Cafeteria Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status. I understand that the change in my benefits election must be necessitated by and consistent with the change of status and that the change must be acceptable under the Regulations issued by the Department of the Treasury. The administrator may require you to provide evidence to document the event that requires the change of election.

I CERTIFY THAT I HAVE INCURRED THE FOLLOWING CHANGE OF STATUS:

Change in Marital Status
☐ Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment

Change in Number Dependents
☐ Change in the number of dependents including birth, adoption, placement for adoption or death of a dependent

Changes in Spouse or Dependent's Eligibility Under an Employer's Plan
☐ Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.
☐ Judgment, decrees, or orders including the imposition of a Qualified Medical Child Support Order

Change in Employment Status that *Changes Eligibility Status*
☐ Change of employment status, such as termination or commencement of employment by the employee, spouse, or Dependent
☐ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse, or dependent, including a switch between part-time and full-time (or vice-versa), a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence.

Other
☐ Change in eligibility due to change in residency of the employee, spouse, or dependent (i.e. moving out of HMO area)
☐ Special requirements relating to the Family and Medical Leave Act (FMLA) for the employee
☐ Gain or loss of Medicaid or Medicare entitlement
☐ Change in H.S.A. (applies to H.S.A. Benefits only may be done prospectively for any reason)
☐ Reduction in hours of service without loss of coverage (relates only to Core Medical Plans)
☐ Eligible for special enrollment period in a qualified health plan offered through a marketplace (relates only to Core Medical Plans)

Change in Cost or Coverage (does NOT apply to Medical Reimbursement Accounts)
☐ Significant cost increase in you or your dependent's coverage
☐ Significant curtailment of you or your dependent's coverage
☐ Addition or elimination of benefit package option under your or your dependent's employer's plan
☐ Change in coverage or open enrollment of spouse or dependent under another employer's plan provided that the employee, spouse, or dependent elects coverage under the dependent's plan
☐ Dependent Care provider is replaced by another
☐ Entitlement to COBRA (relates only to Core Medical Plans)
☐ HIPAA Special Enrollment Rights (relates only to Core Medical Plans)

PLEASE CHANGE MY ELECTION(S) AS FOLLOWS:

Insurance Plans (ex. Health Insurance)
Change my insurance premiums to $_____ per pay period effective with the _____ payroll.

Medical Reimbursement Account
Change my **ANNUAL** election for my Medical Reimbursement Account from $_____ to $_____. My new per pay deduction will be $_____ effective with the _____ payroll.

Dependent Care Reimbursement Account
Change my **ANNUAL** election for my Dependent Care Reimbursement Account from $_____ to $_____. My new per pay deduction will be $_____ effective with the _____ payroll.

Health Savings Account
Change my **PER PAY** election for my Health Savings Account from $_____ to $_____ effective with the _____ payroll.

I understand that I may be required to provide documentation for changes I have requested, that election changes must comply with the Plan, and that the Administrator has sole discretion to make this determination. If I am requesting a change to cancel or reduce coverage because (a) I or my family member have become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or have become entitled to Medicare /Medicaid; or (b) judgment, decree, or order requires an individual other than me to provide accident or health coverage for my child, 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 I am requesting a change to cancel Medical Insurance coverage because of reduction of hours, I certify that I (and any related individuals whose coverage is being canceled) have enrolled or intend to enroll in another plan providing minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date on which I wish to revoke the Medical Insurance Plan coverage. If I am requesting a change to cancel Medical Insurance coverage because of Exchange enrollment, I certify that I (and any related individuals whose coverage is being canceled) have enrolled or intend to enroll for new Exchange coverage that is effective no later than the day after the date on which I wish to revoke the Medical Insurance Plan coverage.

PLEASE NOTE: This form needs to be signed and dated within 30 days after the actual event date listed above.

_____

Employee Signature Date

Accepted and agreed to by:

_____

Employer Representative Signature Date