Change Form for Elections

Section 125 Cafeteria Plan

Participant must apply within 30 days of the qualifying event for a change.

Part A – To be completed by Human Resources

Group name ______________________ ☐ Termination ☐ Change

Effective date of change ______________________ Pay period ____________ to ____________

Remaining number of pay periods (in plan year) ______________________

Part B – To be completed by employee

Name ____
First middle last

Social Security number ______________________ Birth date ______________________

If recent change in address, please update ____
Street City State ZIP code

Date of the following eligible qualifying event ______________________

Marital status change
- ☐ Marriage New last name ______________________
  New spouse name ______________________
- ☐ Divorce
- ☐ Death
- ☐ Legal separation
- ☐ Annulment

Participant employment status change
- ☐ Unpaid leave of absence
- ☐ Return from unpaid leave of absence
- ☐ Part-time to full-time or reverse

Dependent care change
- ☐ Change in cost of dependent care services
- ☐ Change in dependent care coverage

Change in cost or coverage
- ☐ Significant cost increase
- ☐ Addition of plan
- ☐ Significant improvement of coverage
- ☐ Elimination of plan
- ☐ Significant coverage curtailment
- ☐ Change in coverage under other employer plan
- ☐ Loss of coverage under group health plan of governmental or educational institution

Change of dependent status
- ☐ Birth
- ☐ New dependent
- ☐ Adoption
- ☐ No longer dependent
- ☐ Death

Name of dependent affected ______________________

Spousal employment status change
- ☐ Spouse commencement of employment
- ☐ Spouse part-time to full-time or reverse
- ☐ Spouse termination of employment

Other qualifying event
- ☐ Dependent enrollment in COBRA
- ☐ HIPAA special enrollment rights
- ☐ Judgment, decree, or order
- ☐ Gain or loss of Medicare or Medicaid entitlement

Name of family member affected ______________________

Please make the following change(s) to my election(s):

☐ Medical Expense Reimbursement Account $____________ per year

☐ Dependent Care Reimbursement Account $____________ per year

☐ Premium Expense ☐ Begin withholding ☐ Discontinue withholding ☐ Change to new amount ____________

continued

I certify that I or a family member have experienced the qualifying event indicated above. I understand that:

- Any funds remaining in my reimbursement account(s) at the end of the plan year will be forfeited to my employer.
- If my employment terminates for any reason, I am bound by the terms of the summary plan description for the Section 125 Cafeteria Plan.
- Any receipt I submit to my reimbursement account(s) must be for an eligible expense incurred during the applicable plan year.
- The above election change must be on account of and consistent with the qualifying event which permitted the change.
- The above election change must comply with the terms of the summary plan description for the Section 125 Cafeteria Plan.
- I may be required to provide appropriate documentation for the above election change.

I certify that any expense I submit to my reimbursement account(s) has not been reimbursed and will not be reimbursed under any other plan.

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Employee's signature Date

If you are changing your medical expense or dependant care reimbursement account election, return this form to:
Everence Association, Inc.
attn: TPA Services
P.O. Box 483
Goshen, IN 46527-0483

Medical expense and dependant care reimbursement benefits are administered by:

The Harrison Group, Inc.
3 Raymond Drive, Suite 201
Havertown, PA 19083
Phone: (610) 853-9075 Fax: (610) 853-9079
Email: service@theharrisongrouponline.com

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