

# 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

#### Change of dependent status

- Birth  
 New dependent  
 Adoption  
 No longer dependent  
 Death

Name of dependent affected \_\_\_\_\_

#### Participant employment status change

- Unpaid leave of absence  
 Return from unpaid leave of absence  
 Part-time to full-time or reverse

#### Spousal employment status change

- Spouse commencement of employment  
 Spouse part-time to full-time or reverse  
 Spouse termination of employment

#### Dependent care change

- Change in cost of dependent care services  
 Change in dependent care coverage

#### Other qualifying event

- Dependent enrollment in COBRA  
 HIPAA special enrollment rights  
 Enrollment in Health Insurance Marketplace  
 Judgment, decree, or order  
 Gain or loss of Medicare or Medicaid entitlement

#### 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

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 \_\_\_\_\_

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 dependent 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 dependent care reimbursement benefits are administered by:*

**The Harrison Group, Inc.**

3 Raymond Drive, Suite 201

Havertown, PA 19083

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