

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.

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

Phone: (610) 853-9075 Fax: (610) 853-9079

Email: service@theharrisingrouponline.com