

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

Group name _____ ☐ Termination ☐ Change

Effective date of change _____ Pay period _____ to _____

Remaining number of pay periods (in plan year) _____

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 _____

☐ Marriage New last name _____
New spouse name _____

☐ Divorce

☐ Death

☐ Legal separation

☐ Annulment

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

☐ Change in cost of dependent care services

☐ Change in dependent care 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

☐ Birth
☐ New dependent
☐ Adoption
☐ No longer dependent
☐ Death

Name of dependent affected _____

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

- ☐ 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

Name of family member affected _____

☐ 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 dependent care reimbursement account 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 dependent care reimbursement account has not been reimbursed and will not be reimbursed under any other plan.

Employee's signature

Date

If you are changing your dependent care reimbursement account election, return this form to:

**Everence Association, Inc.
attn: TPA Services
P.O. Box 483
Goshen, IN 46527-0483**

*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

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