# 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

☐ Enrollment in Health Insurance Marketplace

☐ 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.

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@theharrisongrouponline.com

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