CAFETERIA PLAN CHANGE IN ELECTION FORM

EMPLOYEE INFORMATION			
Last Name	First	Middle	Hire Date
Address			Birth Date
City, State, Zip			Social Security Number
Company Name			

ELECTION CHANGE REQUESTED Change must have occurred within 30 days. (Check Applicable Boxes)

☐ **REVOCATION OF AN EXISTING ELECTION** Effective Date of Revocation: _____

Type(s) of Coverage Being Revoked:

- ☐ Group Health Insurance Premiums
- ☐ Group Dental Insurance Premiums
- ☐ Aflac Insurance Premiums
- ☐ Full/Limited Medical Flexible Spending Account Benefits
- ☐ Dependent Care Expense Reimbursement Benefits
- ☐ Health Savings Account Benefits

☐ **NEW ELECTION** Effective Date of New Election: _____

New Coverage Level:

_____ New amount of Group Health insurance premium (annual)

_____ New amount of Group Dental insurance premium (annual)

_____ New amount of Aflac premium (annual)

_____ New amount of full medical expense reimbursement (annual) New amount of

_____ limited medical expense reimbursement (annual) New amount of dependent

_____ care expense reimbursement (annual) New amount of Health Savings Account

_____ contribution (annual) New 401K contribution (annual)

_____ New amount of cash contribution – fully taxable (annual)

_____ New Total election (annual)

_____

THE CHANGE IN ELECTION EVENT(S) ON WHICH MY REQUEST IS BASED IS/ARE:

☐ **CHANGE IN MARITAL STATUS**

☐ Marriage ☐ Divorce or Annulment ☐ Legal Separation ☐ Death of Spouse

☐ **CHANGE IN NUMBER OF TAX DEPENDENTS**

☐ Birth ☐ Adoption or placement for Adoption ☐ Death of Dependent

☐ **CHANGE IN EMPLOYMENT STATUS THAT EFFECTS ELIGIBILITY**

Termination of Employment	☐ You	☐ Spouse/Dependent
Commencement of Employment	☐ You	☐ Spouse/Dependent
Part-time to Full-time	☐ You	☐ Spouse/Dependent
Full-time to Part-time	☐ You	☐ Spouse/Dependent
Other	☐ You	☐ Spouse/Dependent

Provide Details

☐ **CHANGE IN DEPENDENT/SPOUSE'S ELIGIBILITY UNDER AN EMPLOYER'S PLAN**

☐ Lost Eligibility (due to age, student status, marital status, etc.) ☐ Gained Eligibility

☐ **CHANGE IN DEPENDENT CARE COST/PROVIDER**

☐ Significant cost increase or decrease ☐ Change of dependent care provider

☐ **OTHER EVENT**

Provide Details

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with the Plan, and the Administrator has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or under Medicare/Medicaid, or (b) a judgment, decree or order requires an individual other than me to provide accident or health coverage for my child, I certify that such new, improved or court ordered coverage has already been obtained or is in the process of being obtained for the applicable person.

If my change in election is denied, I understand that I will have to appeal to the decision within the time frame specified in the Summary Plan Description for the Plan.

Duty to review payroll records. If my change of election is approved, I understand that I have a duty to review my pay records to confirm the employer has properly implemented my pre-tax salary reduction change. Furthermore, I have a duty to inform the Plan Administrator if I discover any discrepancy between my pay records and this Change in Election Form. I understand that my failure to report any discrepancy may result in a loss of benefits.

If Approved, I Hereby Elect the Changes(s) Noted above and Attest That the Change Is Made on Account of and Is Consistent With the Change in Election Event.

Employee Signature Date

Accepted and agreed to:

Administrator's Signature Date

☐ **COBRA ELECTION**

I elect to continue coverage through the end of the Plan Year and will voluntarily pay for such coverage out of My final paycheck on a pre-tax basis, or pay monthly installments on an after-tax basis.

Employee Signature Date

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