## **Change Form for Elections**

governmental or educational institution

Please make the following change(s) to my election(s):

☐ Dependent Care Reimbursement Account \$\_\_\_\_\_\_ per year

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 Effective date of change \_\_\_\_\_\_\_ to \_\_\_\_\_\_ to \_\_\_\_\_\_ Remaining number of pay periods (in plan year) \_\_\_\_\_ Part B – To be completed by employee Name \_\_\_ middle First 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 Change of dependent status ☐ Marriage New last name ☐ Birth New spouse name \_\_\_\_\_ ☐ New dependent ☐ Divorce ☐ Adoption ☐ Death ☐ No longer dependent ☐ Legal separation Death ☐ Annulment Name of dependent affected \_\_\_\_\_ Participant employment status change ☐ Unpaid leave of absence Spousal employment status change Return from unpaid leave of absence ☐ Spouse commencement of employment Part-time to full-time or reverse ☐ Spouse part-time to full-time or reverse ☐ Spouse termination of employment Dependent care change ☐ Change in cost of dependent care services Other qualifying event ☐ Change in dependent care coverage ☐ Dependent enrollment in COBRA ☐ HIPAA special enrollment rights Change in cost or coverage ☐ Enrollment in Health Insurance Marketplace ☐ Significant cost increase ☐ Judament, decree, or order ☐ Addition of plan ☐ Gain or loss of Medicare or Medicaid entitlement ☐ Significant improvement of coverage ☐ Elimination of plan Name of family member affected \_\_\_\_\_ ☐ Significant coverage curtailment ☐ Change in coverage under other employer plan ☐ Loss of coverage under group health plan of

☐ Premium Expense ☐ Begin withholding ☐ Discontinue withholding ☐ Change to new amount \_\_\_\_\_\_

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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@theharrisongrouponline.com