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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