

**CHANGE IN ENROLLMENT FORM**

**EMPLOYEE INFORMATION**

Company Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Employee Name: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ City State Zip Code

**ELECTION CHANGE REQUESTED**

**Revocation of an existing election**

Effective \_\_\_\_\_, I wish to revoke my existing election under the Flexible Benefit Plan.  
 Type of coverage being revoked (my prior election for all other types of coverage remains in effect):  
 Insurance for:  Myself  Spouse  Dependent(s) \_\_\_\_\_  
 Flexible Spending Account  
 Dependent Care Expense Reimbursement Plan

**New Election**

Effective \_\_\_\_\_, I hereby make a new election as specified below.

**Please indicate appropriate change:**

**Date Change Occurred:**

- Marriage or Divorce \_\_\_\_\_
- Death of spouse or dependent \_\_\_\_\_
- Birth or Adoption of child \_\_\_\_\_
- Termination or commencement of employment of self \_\_\_\_\_
- Termination or commencement of employment of spouse \_\_\_\_\_
- Job status (part time/fulltime) for employee or spouse \_\_\_\_\_
- Significant change in insurance premium or coverage \_\_\_\_\_
- Significant change in cost of dependent care \_\_\_\_\_
- Administrative Error (attach explanation) \_\_\_\_\_
- Other: \_\_\_\_\_

FSA or Child Care	Current Amount (Per Pay Period)	New Amount (Per Pay Period)	New Annual Election	Payroll Effective Date
1. _____	\$ _____	\$ _____	\$ _____	_____
2. _____	\$ _____	\$ _____	\$ _____	_____
3. _____	\$ _____	\$ _____	\$ _____	_____

**AGREEMENT**

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

**Under your Section 125 Plan you may be reimbursed for expenses for yourself, your spouse, and your dependents, as defined in the Internal Revenue Code.**

I certify If change of my election is denied, I understand I will have to appeal the decision within the time frame specified in the Summary Plan Description for the Plan. If approved, I hereby elect the change(s) noted above and attest that the change is made on account of, and is, consistent with the change in election event.

\_\_\_\_\_  
Employee Signature  
  
\_\_\_\_\_  
Administrator Signature

\_\_\_\_\_  
Date  
  
\_\_\_\_\_  
Date