



**Reason for Election Change (continued)**

**c. Change in Employment Status With Gain or Loss of Eligibility -**

- Change relates to:  Employee  Spouse or Dependent
- |  |             |  |             |
|--|-------------|--|-------------|
| <input type="checkbox"/> Termination of Employment on  | ___/___/___ | <input type="checkbox"/> Full-time to Part-time on   | ___/___/___ |
| <input type="checkbox"/> Commencement of Employment on   | ___/___/___ | <input type="checkbox"/> Part-time to Full-time on   | ___/___/___ |
| <input type="checkbox"/> Commencement of Unpaid Leave on   | ___/___/___ | <input type="checkbox"/> Return from Unpaid Leave on | ___/___/___ |
| <input type="checkbox"/> Other (hourly to salary, union to non union, change in worksite, etc.) on | ___/___/___ |  |             |

Provide Details: \_\_\_\_\_

**d. Change in Dependent Eligibility Under an Employer's Plan**

- Lost Eligibility (age, student status, attainment of age 13 for Dependent Care FSA, COBRA event, etc.) on \_\_\_/\_\_\_/\_\_\_
- Gain Eligibility (e.g., age, student status, etc.) on \_\_\_/\_\_\_/\_\_\_

**e. Change of Residence Affecting Eligibility –**

Change relates to:  Employee  Spouse or Dependent Date of change \_\_\_/\_\_\_/\_\_\_

**2. Special Enrollment Rights – HIPAA (applies to Premium benefits only)**

- Loss of other group health plan coverage on \_\_\_/\_\_\_/\_\_\_
- Acquired new spouse or dependent (marriage, birth, etc.) on \_\_\_/\_\_\_/\_\_\_
- Eligible for Premium Assistance Subsidy on \_\_\_/\_\_\_/\_\_\_

**3. Certain Judgments, Decrees and Orders (applies to Premium and Health FSA benefits only)**

- Court order requiring coverage for Dependent on \_\_\_/\_\_\_/\_\_\_

**4. Medicare or Medicaid (applies to Premium and Health FSA benefits only)**

- Became eligible for Medicare or Medicaid on \_\_\_/\_\_\_/\_\_\_
- Became ineligible for Medicare or Medicaid on \_\_\_/\_\_\_/\_\_\_

**5. Change in Cost (applies to Premium)**

- Significant cost increase in coverage on \_\_\_/\_\_\_/\_\_\_
- Significant cost decrease in coverage on \_\_\_/\_\_\_/\_\_\_

**6. Change in Coverage (applies to Premium)**

- Change in dependent care provider on \_\_\_/\_\_\_/\_\_\_
- Significant curtailment of coverage on \_\_\_/\_\_\_/\_\_\_
- Addition or significant improvement of a plan option on \_\_\_/\_\_\_/\_\_\_
- Loss of group health coverage under plan of a governmental or educational institution on \_\_\_/\_\_\_/\_\_\_
- Change in coverage under an employer's plan on \_\_\_/\_\_\_/\_\_\_

**Signature**

I have examined this authorization to modify my Salary Reduction Agreement and to the best of my knowledge, it is true, correct and complete. I understand that the election change I have requested must be on account of and consistent with the status change or other election change event (s) I have checked above. I understand that the status and participation changes must comply with the Plan and that the Plan Administrator has the sole discretion in making this determination. I further understand that I may be required to provide documentation regarding the change(s) I have checked above.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

**Sec 132 and Sec 125 FSAs must indicate the LAST PAY DATE affected (may differ from actual Termination Date):** \_\_\_/\_\_\_/\_\_\_

Denied by \_\_\_\_\_ on \_\_\_\_\_

Reason for Denial \_\_\_\_\_

Action to be taken \_\_\_\_\_

Plan Administrator \_\_\_\_\_

Agreed and accepted by the Employer's Representative

\_\_\_\_\_  
Date