

# CAFETERIA PLAN CHANGE IN ELECTION FORM

## EMPLOYEE INFORMATION

Name	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:

- Outside Health Insurance Premiums
- Aflac Insurance Premiums
- Full / Limited Medical Flexible Spending Account Benefits
- Dependent Care Expense Reimbursement Benefits
- Health Savings Account Benefits
- 401K Contribution
- Cash (fully taxable)

**NEW ELECTION**      Effective Date of New Election: \_\_\_\_\_

New Coverage Level:

EMPLOYEE	EMPLOYER	
_____	_____	New amount of outside health insurance premium reimbursement (annual)
_____	_____	New amount of Aflac premium reimbursement (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 Saving Account contribution (annual)
_____	_____	New 401K contribution (annual)
_____	_____	New amount 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	<input type="checkbox"/> You	<input type="checkbox"/> Spouse/Dependent
Commencement of Employment	<input type="checkbox"/> You	<input type="checkbox"/> Spouse/Dependent
Part-time to Full-time	<input type="checkbox"/> You	<input type="checkbox"/> Spouse/Dependent
Full-time to Part-time	<input type="checkbox"/> You	<input type="checkbox"/> Spouse/Dependent
Other	<input type="checkbox"/> You	<input type="checkbox"/> 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 election is approved, I understand that I have a duty to review my pay records to confirm the employer properly has 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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