

Change in Election Form/Salary Reduction Agreement

Employers Name: _____

Name: _____

Address: _____

1. ELECTION CHANGE REQUESTED (Check Applicable Boxes)

REVOCATION OF AN EXISTING ELECTION

Effective _____, I wish to REVOKE my existing election under the ABC, Inc. Salary Reduction Plan (with Premium Payment, Health FSA, HSA, and DCAP Components) ("the Plan").

Type of coverage being revoked (my prior election for all other types of coverage remains in effect):

- Medical Insurance
 - for myself
 - for spouse
 - for dependent(s) _____
- Health FSA Benefits
- HSA Benefits
- DCAP Benefits

NEW ELECTION

Effective _____, I hereby make a new election as specified on the attached Election Form/Salary Reduction Agreement for the Plan.

2. THE CHANGE IN ELECTION EVENT(S) ON WHICH MY REQUEST IS BASED IS/ARE:

Check Applicable Box(es) to indicate the Change in Election Event(s) that apply to your situation. Election changes generally cannot be retroactive and must be consistent with the Change in Election Event, as described at the end of this Form.

A. **Changes in Status** (applies to Premium Payment, Health FSA, and DCAP Benefits; for Health FSA Benefits, may seek to increase or cancel, but not reduce coverage)

1. Change in Marital Status

- Marriage
- Divorce or annulment
- Legal separation
- Death of spouse

2. Change in Number of Tax Dependents

- Birth
- Adoption or placement for adoption
- Death of dependent

¹ In no event may the revocation/new election be effective prior to the first day of the month beginning after this Form is completed and returned to the Administrator, unless medical coverage is being added pursuant to HIPAA special enrollment due to the acquisition of a new dependent by birth, adoption, or placement for adoption, in which case the new election may be consistent with the new medical insurance election, as applicable.

3. Change in Employment Status That Affects Eligibility

| | You | Your Spouse or Dependent |
|----------------------------|--------------------------|-----------------------------|
| Termination of employment | <input type="checkbox"/> | <input type="checkbox"/> |
| Commencement of employment | <input type="checkbox"/> | <input type="checkbox"/> |
| Part-time to full-time | <input type="checkbox"/> | <input type="checkbox"/> |
| Full-time to part-time | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

Provide details _____

4. Change in Dependent's Eligibility Under an Employer's Plan

- Lost eligibility (such as age, student status, marital status)
- Gained eligibility (such as age, student status, marital status)

5. Change in Residence Affecting Eligibility

| You | Your Spouse or Dependent |
|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

B. Change in DCAP Cost/Provider (applies to DCAP Benefits only)

- Significant cost increase or decrease in cost of coverage
- Changed dependent care providers

C. Change in HSA (applies to HSA Benefits only; may be done prospectively for any reason)

D. Other Event (see your Summary Plan Description for the list of other events that permit a change in election)

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 has become entitled to 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 the decision within the timeframe specified in the Summary Plan Description for the Plan.

If approved, I hereby elect the change(s) noted on the attached Election Form/Salary Reduction Agreement and attest that the change is made on account of and is consistent with the change in election event.

Employee's Signature

Date

Accepted and agreed to:

Administrator's Signature

Date