

Salary Reduction Agreement Change and Revocation Form

Company Name: _____

Plan Year: _____

I. Participant Identification (please print or type)

Participant Name: _____

Social Security Number: ____ - ____ - _____

II. Change or Revocation of Salary Reduction Agreement

Please indicate the change in your Salary Reduction Agreement in the area below. If there is a status change event, change in cost/coverage or other-type change (judgment decrees, etc.) that is permitted under the Internal Revenue Code and Regulations, and which justifies a change in your Salary Reduction Agreement, you may change or revoke your Salary Reduction Agreement. However, once you make the change indicated on this form, you may not reinstate or revise your Salary Reduction Agreement as of a date before the first day of the next Plan Year unless there is another status change event, change in cost/coverage or other-type allowable change (judgments, decrees, etc.).

Premium-type Benefits

If you are changing from one level of coverage, from single to family coverage for example, mark "Revoke" for your current coverage (e.g. single) and mark "New Enrollment" for the new coverage (e.g. family).

If you are ending participation in the Plan, mark "Revoke".

<u>Current Election</u>	<u>Revoke/Suspend</u>	<u>New Enrollment</u>	<u>Effective Date</u>
** Health Insurance **			
[] Employee Only	[]	[]	___/___/___
[] Employee Plus Dependents	[]	[]	___/___/___
** Dental **			
[] Employee Only	[]	[]	___/___/___
[] Employee Plus Dependents	[]	[]	___/___/___
** _____ **			
[] Employee Only	[]	[]	___/___/___
[] Employee Plus Dependents	[]	[]	___/___/___

Flexible Spending Arrangements

If you are reducing or increasing your salary reductions, please indicate the new amount PER PAY PERIOD under "New Enrollment". If you are ending participation in the Plan, mark "Revoke".

<u>Current Election</u>	<u>Revoke/Suspend</u>	<u>New Enrollment Salary Reduction</u>	<u>Effective Date</u>
[] Dependent Care FSA	[]	_____.	___/___/___
[] Medical Expense FSA	[]	_____.	___/___/___

III. Reason for Election Change – please mark [X] the appropriate election change event(s) that justifies the change(s) or revocation(s) on this form and enter the date(s) of the event(s)

1. Status Change Events

a. Change in Marital Status

[] Marriage on	___/___/___	[] Legal Separation on	___/___/___
[] Divorce on	___/___/___	[] Death of Spouse on	___/___/___
[] Annulment on	___/___/___		

b. Change in Number of Tax Dependents

[] Birth on	___/___/___	[] Death of Dependent on	___/___/___
[] Adoption on	___/___/___	[] Death of Spouse on	___/___/___
[] Other – Gain Tax Dependent on	___/___/___		

III. Reason for Election Change (continued)

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

- Change relates to: Employee Spouse or Dependent
- Termination of Employment on ___/___/___ Full-time to Part-time on ___/___/___
- Commencement of Employment on ___/___/___ Part-time to Full-time on ___/___/___
- Commencement of Unpaid Leave on ___/___/___ Return from Unpaid Leave on ___/___/___
- 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 ___/___/___

f. Commencement or Termination of Adoption Proceedings

- (applies to Dependent Care FSAs only) 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 ___/___/___

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 and Dependent Care FSA benefits only)

- Significant cost increase in coverage on ___/___/___
- Significant cost decrease in coverage on ___/___/___

6. Change in Coverage (applies to Premium and Dependent Care FSA benefits only)

- 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 ___/___/___

IV. 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

Plan Administrator:

Agreed and accepted by the Employer's Representative

Date

Denied by _____ on _____

Reason for Denial _____

Action to be taken _____