

CHANGE OF ELECTION/STATUS

Please Print Employee's Name	Employee's Social Security #
Employee's Address	
Employer Name/Division (if applicable)	Payroll Effective Date

Instructions: Use this form to change elections previously made, but only in the event of a "change in status". A change can only be made once per qualifying event and must be consistent with the reason for change. Use the front part of the form to indicate the change and the reverse side to indicate the corresponding payroll increase / decrease.

Please check the appropriate box:

Change of Status:

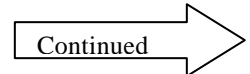
- Marriage/Divorce/Legal Separation/Annulment**
- Satisfy/Cease to Satisfy Dependent Status/Attainment Age Effecting Eligibility (Student Status/Medicare or Medicaid/State Insurance Program)**
- Birth/Adoption/Placement for Adoption/Death**
- Change in Employment Status Employee/Spouse/Dependent (termination/commencement /part-time to full-time/full-time to part-time/strike or lockout/ unpaid leave of absence/return from leave of absence/change in work site)**
- Change in Residence**

Dependent Care and Insurance Changes Only:

- Significant Cost Increase/Decrease in coverage for you or your dependent(s)**
- Significant Curtailment in coverage for you or your Dependent(s)**
- Addition or Elimination of Benefit Package Option under yours or your Dependent's Plan.**
- Change in Coverage or Open Enrollment of Spouse or Dependent's coverage under another Employer's Plan**
- Judgement, Court Order or Decree resulting from Divorce, Legal Separation, etc. (i.e. child support order)**
- Other**

Please provide an explanation of the Change in Status or Change in Cost of Coverage and describe how the change is

consistent with the event: _____



Employer Name _____ Employee Name _____ SSN _____

EMPLOYEE SECTION

I hereby request a change in my benefit election(s) as follows:

PREMIUMS: (Identify below as applicable: Health, Dental, Disability, Life, Vision, Cancer, Accident, Hospital Indemnity, Intensive Care, etc.)

Table with columns: PREMIUM (indicate type), PAY PERIOD (From \$, To \$), NEW ANNUAL (\$). Rows include GENERAL-PURPOSE MEDICAL REIMBURSEMENT, LIMITED-PURPOSE MEDICAL REIMBURSEMENT, DEPENDENT CARE EXPENSES, HEALTH SAVINGS ACCOUNT (HSA)*.

*Benefit elections not changed above shall remain in effect until the plan anniversary date except in case of an eligible change in status; however, HSA contributions can be changed as set forth in IRS Code §223, the provisions of the plan, and/or without a required qualifying event.

Please sign and return this form to your employer. I hereby elect the change(s) noted on this form and attest that the change is made on account of and conforms with the Change in Status or Change in Cost or Coverage Event. (I understand that I may be required to provide the appropriate documentation for any changes listed above.)

Employee's Signature _____ Date _____

EMPLOYER SECTION

Termination of Employment:

Circle One: Voluntary Involuntary
Termination Date: _____

Leave of Absence from Employment:

Circle One: FMLA Non-FMLA USERRA Worker's Comp
Leave of Absence Date*: _____
*Attach completed Leave of Absence Form

Please indicate how much was deducted (per option) for the Plan Year. Forward to Benefits Design Group, Inc.; retain photocopy for your records, if desired.

**General Purpose Medical Reimbursement \$ _____ OR **Limited Purpose Medical Reimbursement \$ _____
Remaining Balance: \$ _____ COBRA Eligible: Yes _____ No _____

**Contact Benefits Design Group, Inc. for balance information and assistance determining COBRA eligibility.

Table with columns: Dependent Care, Dental Premium, After Tax Deductions, HSA Deductions, Individual Premium, Disability Premium, Other Premiums (indicate type), Health Premium, Term Life Premium, Other Premiums (indicate type). Each cell contains a dollar sign and a blank line for input.

Employer/Payroll

Signature _____ Date _____

EECHNGLnew04/06

BENEFITS DESIGN GROUP, INC.

PO BOX 370 ONALASKA WI 54650

PHONE: 1-800-554-7213 OR 1-800-342-8235 FAX NUMBER: 1-608-781-4576