ERISA ADMINISTRATIVE SERVICES, INC.

FLEXIBLE BENEFITS PLAN CHANGE AND REVOCATION FORM

PERSONAL DATA (Please Print)

Last	*First*	*MI*	*SSN (Last 4)* XXX-XX-

Address	*City*	*State*	*Zip*

Plan Year	*Phone Number*	*Email*

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.). Please Note: In most circumstances, you must submit the Change and Revocation Form within **30 days** of qualifying event.

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".

Current Election	Revoke/ Suspend	New Enrollment	Effective Date
Health Insurance			
☐ Employee Only	☐	☐	______________
☐ Employee Plus Dependents	☐	☐	______________
Dental			
☐ Employee Only	☐	☐	______________
☐ Employee Plus Dependents	☐	☐	______________
Vision			
☐ 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".

Current Election	Revoke/ Suspend	New Salary Reduction	Effective Date
☐ Health FSA	☐	______________	______________
☐ Dependent Care Assistance Program	☐	______________	______________

REASON FOR ELECTION CHANGE

Please mark 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: ______________
☐ Divorce on: ______________
☐ Annulment on: ______________
☐ Legal Separation on: ______________
☐ Death of Spouse on: ______________

b. Change in Number of Tax Dependents

☐ Birth on: ______________
☐ Adoption on: ______________
☐ Other – Gain Tax Dependent on: ______________
☐ Death of Dependent on: ______________
☐ Death of Spouse on: ______________

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 DCAP, COBRA event, etc.) on: ______________
☐ Gain Eligibility (age, student status, etc.) on: ______________

e. Change of Residence Affecting Eligibility Date of Change: ______________

Change relates to: ☐ *Employee* ☐ *Spouse or Dependent*

f. Commencement or Termination of Adoption Proceedings Date of Change: ______________

Applies to Dependent Care Assistance Program only

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 and Dependent Care FSA benefits only)*

☐ Significant cost increase in coverage on: ______________
☐ Significant cost increase 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: ______________

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

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