FLEXIBLE BENEFITS PLAN
CHANGE IN ELECTION FORM

This form is used to change your annual election(s). To make changes to your personal data (name, address, direct deposit bank, etc.), please use the **Change In Data.** Employee (participant) should complete Parts I, II, and III. Employer should complete Part IV.

Company Name:____

Employee Name:______________________________ Social Security: ____________________

Address:____

PART I: Change in Status

I have had the following change in status (as defined in the Plan) since I signed the Election Form (check one):

Leave of Absence and/or Layoff
Date of Leave/Layoff:____________________
Date of Last Payroll Deduction:_______________________
Does of Leave Qualify under FMLA? Yes No
I have taken an unpaid leave of absence.

My spouse or dependent has taken an unpaid leave of absence.

I have terminated employment

Date of last payroll deduction:_______________________ Date of termination:____________________

I have married.

I have divorce or legally separated or my marriage has been annulled.

My dependent (i.e., spouse, child or other dependent) has died.

I have had a child (by birth, adoption or placement for adoption).

My spouse or dependent has terminated employment.

My employment status is affected by strike or lockout.

The employment status of my spouse or dependent is affected by a strike or lockout.

I have changed my work site.

My spouse or dependent has had a change in work site.

I have had the following change in employment status which affects my eligibility for benefits
Explain:____

My spouse or dependent has had the following change in employment status, which affects his or her eligibility for benefits. Explain:____

My dependent **now** satisfies the requirements for coverage due to the attainment of a specified age, student status or similar circumstance.

My dependent **ceases** to satisfy the requirements for coverage due to the attainment of a specified age, student status or similar circumstance.
I have changed my place of residence.

My spouse or dependent has changed his or her place of residence.

I am returning from an FMLA leave and elect to reinstate my election with respect to Employer's group health insurance plane [and/or the Medical Spending Account].

My cost for dependent care services has increased or decreased and I elect to make a corresponding change under my Dependent Care Spending Account. (Note-an election change is not permitted in this situation if your dependent care provider is your relative.)

My spouse, former spouse or dependent is enrolled in his or her employer's plan and that plan has a different 12-month election year than this Plan. My spouse, former spouse or dependent has made an election during the open enrollment period of his or her employer's plan and I elect to make an election change which is on account of, and corresponds with, the election change under the other plan. (Note-an election change is not permitted in this situation with respect to your Medical Spending Account.)

A court order resulting from divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) has been entered regarding accident or health coverage for my child. If the order requires coverage under Employer's group health insurance plan, I elect coverage for my child. If the order requires my spouse, former spouse, or other individual to provide accident or health coverage, I elect to cancel Employer provided coverage for my child.

I, my spouse or my dependent has become entitled to Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits) and I elect to cancel or reduce Employer-provided accident or health coverage for the affected individual(s).

I, my spouse or my dependent that has been entitled to Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits) has lost eligibility for such coverage and I elect to begin or increase Employer provided accident or health coverage for the affected individual (s).

Other: I feel I have a change in status NOT listed above.

Explain:____

If I have a change in status as indicated above, I understand that I may change my election only if it is on account of, and corresponds with the change. Here are some examples:

- If I get married or have a baby I may elect to increase the number of my dependents on my group health coverage and/or increase my Medical Spending Account election for the plan year.

- If my spouse terminates employment and loses eligibility for group health coverage through his or her former employer I may elect to add my souse to my group health coverage.

- If my child turns 13 and I am no longer eligible to obtain reimbursement for my child's dependent care under my Dependent Care Spending Account, I may elect to discontinue my election.

- If I move my place of residence and am no longer in the service area of the HMO in which I am enrolled, I may elect to switch to other group health coverage.

Exceptions to the "on account of corresponds with" rule are available where:

- Your spouse or dependent has a change in status, which causes a loss in eligibility under your group health coverage. In this situation, you may increase your pre-tax reductions to pay for the cost of their COBRA.

- If you and your spouse have a change in marital status or if your spouse or dependent has a change in employment status, your disability income benefits and/or group term life insurance benefits election(s) may be increased or decreased.

PART II: Benefit Election Changes

In accordance with the change in status described above, I elect to change my benefit election under the Plan. Please complete the following information (all account information is available at www.flexchecks.com):

Current Election Information

Benefit	Column A Current Annual Election	Column B Current Per Pay Period	Column C YTD Contributions thru ___/___/___	Column D Reimbursements thru ___/___/___
FSA Medical				
FSA Dependent Care				

New Election Information

Benefit	New Per Pay Period Amount	X	# of Pay Periods Remaining in Plan Year	+	YTD Contributions from Column C	=	Column E **New Annual Election** (cannot be less than Column C or D above)
FSA Medical		X		+		=	
FSA DepCare		X		+		=	

PART III: Participant Representations

I understand that the change in my election, as indicated above, will be effective at the time prescribed by the plan administrator. I also understand that this election may not be changed during the remainder of the plan year (ending) unless I have another change for which federal law permits me to make a new election.

I CERTIFY THAT ALL THE INFORMATION IN THIS DOCUMENT IS TRUE. I AGREE TO SUPPLY ANY ADDITIONAL INFORMATION THAT THE PLAN ADMINISTRATOR, IN ITS DISCRETION, DETERMINES IS NECESSARY TO PROCESS MY REQUEST FOR A CHANGE IN MY BENEFIT ELECTION.

Employee's Signature: ____ Date: _______________

PART IV: Employer Verification

NEW ANNUAL FSA MEDICAL $ __________________ (from Column E above)

NEW ANNUAL FSA DEPENDENT CARE $__________________ (from Column E above)

Effective Date: ________________ First payroll date in which change applies:____________________

Employer's Signature:_______________________________________ Date: __________________

Please return this form to:

Flexchecks, Inc. PO Box 141215, Grand Rapids, MI 49514-1215
Phone: 616.791.7900 • Toll Free: 866.791.7900 • FAX: 616.791.7901

Note: If you are faxing this form, please be sure to send all three pages.