PREMIUM ONLY PLAN
CHANGE AND REVOCATION FORM

(Please Print)

PERSONAL DATA **PLAN YEAR**_____ Soc. Sec. #_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

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	[ ]	[ ]	___/___/___
**** _____ ****			
[ ] 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 Enrollment Salary Reduction	Effective Date
[ ] Medical Expense FSA	[ ]	_____.__	___/___/___

*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 ___/___/___
[ ] 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 ___/___/___

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

[ ] Loss 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 – Date of change ___/___/___

Change relates to: *[ ] Employee* *[ ] Spouse or Dependent*

2. Special Enrollment Rights – HIPAA *(applies to Premium benefits only)*

[ ] Lost 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)*

[ ] Significant cost increase in coverage on ___/___/___
[ ] Significant cost decrease in coverage on ___/___/___

6. Change in Coverage *(applies to Premium)*

[ ] 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