EBS can help:

Employee Benefit Systems Third Party Administration Services

Section 125 ENROLLMENT CHANGE

EMPLOYEE INFORMATION

Company Name: _____ **SS#:** _____

Employee Name: _____ **E-mail:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Day-time Phone:** _____

ELECTION CHANGE REQUESTED (must be done within 30 days of the event)

☐ **Revocation of an existing election**

Effective _____, I wish to revoke my existing election under the Flexible Benefit Plan.

Type of coverage being revoked (my prior election for all other types of coverage remains in effect):

☐ Insurance for: ☐ Myself ☐ Spouse ☐ Dependent(s) _____

☐ Flexible Spending Account

☐ Dependent Care Expense Reimbursement Plan

☐ **New Election**

Effective _____, I hereby make a new election as specified below. Election must be requested with 30 days of QLE.

Please indicate appropriate Qualifing Life Event (QLE): **Date Change Occurred:**

☐ Marriage or Divorce _____

☐ Name Change _____

☐ Death of spouse or dependent _____

☐ Birth or Adoption of child _____

☐ Termination or commencement of employment of self _____

☐ Termination or commencement of employment of spouse _____

☐ Job status (part time/fulltime) for employee or spouse _____

☐ Significant change in cost of dependent care _____

☐ Administrative Error (attach explanation) _____

☐ Other: _____

FSA or Dependent Care	Current Amount (Per Pay Period)	New Amount (Per Pay Period)	New Annual Election	Payroll Effective Date
1. _____	$ _____	$ _____	$ _____	_____
2. _____	$ _____	$ _____	$ _____	_____

AGREEMENT

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with the Plan, and the Administrator has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I, or my family member, has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or under Medicare/Medicaid, or (b) a judgment, decree or order requires an individual other than me to provide accident or health coverage for my child, I certify that such new, improved or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person.

_____ _____

Employee Signature *Date*

_____ _____

Client HR Reprensentative Signature *Date*

Employee Benefit Systems ▪ 214 North Main Street ▪ PO Box 1053▪ Burlington, IA 52601
Phone: 800-373-1327 ▪ Fax: 888-511-3743 ▪ flex@ebs-tpa.com

EBS