GUARDIAN®

FlexPlan

SECTION 125 CAFETERIA PLAN
CHANGE IN ELECTION FORM

Company Name: _____ Group Policy Number G-_____

Employee Name: _____

Social Security No. _____ - _____ - _____

Employee Address: _____
Street City State Zip Code

[Check Applicable Box]

☐ **REPLACEMENT OF AN EXISTING ELECTION WITH NEW ELECTION**

Effective ____ /____ /____,* I hereby **REVOKE** my existing election under the Cafeteria Plan, and elect benefits under the Plan as specified on the ***attached Application and Election Form***.

☐ **REVOCATION OF AN EXISTING ELECTION WITHOUT NEW ELECTION**

Effective ____ /____ /____,* I hereby **REVOKE** my existing election under the Cafeteria Plan.

☐ **ELECTION TO PARTICIPATE**

Effective ____ /____ /____,* I hereby elect to participate in the Cafeteria Plan, and elect benefits under the Plan as specified on the ***attached Application and Election Form***.

☐ **FSA ACCOUNTS ONLY**

Please include last contribution date ____ /____ /____. YTD Contributions _____

Check the appropriate box to indicate a Change in Status or a Change in Cost or Coverage. One or more of the following events listed below may qualify you to change your coverage election during the Plan Year. Changes cannot be retroactive and must be made on account of and conform with the events indicated. As a general rule, the consistency requirement will not generally be met for a Change in Status Event unless the event affects eligibility for the coverage sought to be changed under this Plan (or an employer-provided plan of your spouse or dependent). The Plan Administrator has final discretion to determine whether the eligibility requirement has been satisfied.

Changes in Status

- **Change in Marital Status**
  - ☐ Marriage
  - ☐ Divorce or Annulment
  - ☐ Legal Separation
  - ☐ Death of Spouse
- **Change in Number of Tax Dependents**
  - ☐ Birth
  - ☐ Adoption
  - ☐ Placement for Adoption
  - ☐ Death of Dependent
- **Change in Employment Status that Affects Eligibility**

	You	Your Spouse or Dependent
Termination of Employment	☐	☐
Commencement of Employment	☐	☐
Part-time to Full-time	☐	☐
Full-time to Part-time	☐	☐
Strike or Lock-Out	☐	☐
Commencement of unpaid leave of absence.	☐	☐
Return from unpaid leave of absence	☐	☐
Change in Worksite	☐	☐
Other (Salaried to Hourly, etc.)	☐	☐

- **Change in Spouse or Dependent's Eligibility under an Employer's Plan**
  Loses eligibility (age, student status, marital status) ☐
  Gains eligibility (age, student status, marital status) ☐

	You	Your Spouse or Dependent
• **Change in Residence Affecting Eligibility**	☐	☐

Changes in Cost or Coverage

(Note: Changes in Cost or Coverage do *not* allow for changes to health FSAs.)

- **Significant Cost Increase in your or your Dependent's Coverage** ☐
- **Significant Curtailment of your or your Dependent's Coverage** ☐
- **Addition or Elimination of Benefit Package Option under your or your Dependent's Employer's Plan** ☐
- **Change in Coverage or Open Enrollment of Spouse or Dependent under other Employer's Plan** ☐

Please explain the Change in Status or Change in Cost or Coverage event(s) marked above on which you are basing your request for a mid-year coverage change and describe how the requested change is consistent with the event.

_____

_____

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 my employer's plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

I HEREBY ELECT THE CHANGE(S) NOTED ON THE APPLICATION AND ELECTION FORM ATTACHED AND ATTEST THAT THE CHANGE IS MADE ON ACCOUNT OF AND CONFORMS WITH THE CHANGE IN STATUS OR CHANGE IN COST OR COVERAGE EVENT.

Accepted and agreed to

X_____ By: _____
Employee Signature Plan Administrator/Employer

Date: _____ Date: _____