



# Permitted Election Change Form

Secure upload at: **www.ebcflex.com**  
 Fax to: **608 831 4790**  
 Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347  
 Phone support: **800 346 2126**, 608 831 8445, M - F 8:00 - 5:00 Central  
 E-mail support: **employerservices@ebcflex.com**

Participants must submit this form to Employee Benefits Corporation within 30 days of the Qualifying Event. **Please be sure to keep a copy for your records.**

## General Information

Company Name \_\_\_\_\_ Division \_\_\_\_\_

## Account Holder Information

### Social Security or Identification Number (Required)

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth (mm-dd-yyyy) \_\_\_\_\_ E-mail Address (we do not share your e-mail address) \_\_\_\_\_ Hire Date (mm-dd-yyyy) \_\_\_\_\_

## Qualifying Event

Note: Benefit elections not changed will remain in effect until the renewal plan year Effective Date. If this form is completed and signed BEFORE THE QUALIFYING EVENT, THEN THE NEW ELECTION IS EFFECTIVE ON THE DATE OF THE EVENT. If this form is completed and signed AFTER THE QUALIFYING EVENT, THEN THE NEW ELECTION IS EFFECTIVE ON THE DATE OF THE SIGNATURE. The first payroll date affected by the event must occur after the signature date of this form.

**Remember: The revocation and new election must both be as a result of a qualifying event and be consistent with that event.**

Qualifying Event Date (mm-dd-yyyy) \_\_\_\_\_ First Payroll Date Affected By The Qualifying Event (mm-dd-yyyy) \_\_\_\_\_

### Health Care or Limited Health Care Flexible Spending Account (FSA)

Please check only one of the following qualifying events that you have experienced:

- |   |  |
|---|--|
| Change in Marital Status (marriage, divorce, etc.)  | Judgment, Decree, or Court Order                                     |
| Change in Number of Dependents (birth, death, etc.)   | Commencement or termination of your spouse or dependent's employment |
| Change in Employment, including returning from unpaid non-FMLA leave (if eligibility is affected) |  |
| Change in dependent eligibility   | Entitlement to or loss of Medicare or Medicaid                       |
| COBRA event   | Death of spouse or dependent   |

### Dependent Care Flexible Spending or Individual Billed Insurance Premium Accounts (IND)

Please check only one of the following qualifying events that you have experienced:

- |  |   |
|--|---|
| Change in Marital Status (marriage, divorce, etc.)                                       | Change in Provider                                      |
| Change in Number of Dependents (birth, death, etc.)                                      | Commencement or termination of your spouse's employment |
| Change in Employment, including returning from unpaid leave (if eligibility is affected) | Child starts/stops school                               |
| Change in dependent eligibility  | Death of spouse or dependent                            |
| Change in cost   | Change in coverage under another employer's plan        |

**Explanation of Change** **Note:** You may be required to submit documentation to verify your qualifying event.

Please explain below, the election change you wish to make to the Health Care or Dependent Care FSA or the IND account and why the requested change is consistent with your qualifying event. Describe the loss or gain of eligibility for coverage. An election change is consistent only if it is necessary or appropriate as a result of the qualifying event.

**Qualifying Event (cont.)****Group Insurance/Plan Premiums**

**If this is the only section that applies, please do not submit this form to Employee Benefits Corporation; keep a copy for your records only.**

Please check only one of the following qualifying events that you have experienced:

Change in Marital Status (marriage, divorce, etc.)	Judgment, Decree, or Court Order
Change in Number of Dependents (birth, death, etc.)	Commencement or termination of your spouse or dependent's employment
Change in Employment, including returning from unpaid non-FMLA leave (if eligibility is affected)	
Change in dependent eligibility	Addition/elimination of a benefit
Change in Cost/Coverage	Death of spouse or dependent
Change in residence (if eligibility changes)	Loss of coverage under a government or educational institution plan
Change in coverage under another employer's plan including open enrollment under the spouse or dependent's plan	
COBRA event	

**One of the following special enrollment rules that affects premiums**

HIPAA special enrollment (Medical Premium Election may be retroactive to the benefit start date on a pre-tax basis for birth or adoption)	
Entitlement to or loss of Medicare or Medicaid	Health Savings Account (HSA) Monthly Contribution

**Election Information**

	<i>Current Election Amount Per Paycheck</i>	<i>Revised Election Amount Per Paycheck</i>	<i>Revised Annual Election</i>
HSA Contribution:	\$	\$	\$
Group Insurance Premiums:	\$	\$	\$
Health Care FSA:	\$	\$	\$
Limited Health Care FSA:	\$	\$	\$
Dependent Care FSA:	\$	\$	\$
IND Account:	\$	\$	\$

**Account Holder and Employer Signatures**

I have read and fully understand the regulations to change my election. I understand that my Qualifying Event Election Change Form must be completed **no later than 30 days** after the qualifying event, and the election change I have requested must be consistent with that qualifying event. **I understand that any election change will be effective on the later date of the qualifying event or on the date I request the election change.**

I agree this election cannot be revoked or changed during the plan year, unless there is a qualifying event that justifies the revocation or change as authorized by the Internal Revenue Code and Regulations.

**I understand that my Social Security benefits may be affected by my participation in this plan and that any money I allocate to these accounts and do not spend by the end of the plan year cannot be returned to me.** I also understand that, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, Employee Benefits Corporation may need "protected health information" regarding coverage or benefits for me or my dependents under the plan. By signing this Qualifying Event Permitted Election Change Form, I hereby acknowledge Employee Benefits Corporation will obtain and use such information and disclose it to my employer (or to an insurer or other provider of services to the plan), but only for purposes of the plan and only for as long as Employee Benefits Corporation is providing services regarding the plan. Any information disclosed pursuant to this Qualifying Event Permitted Election Change Form will not be subject to redisclosure by the recipient, except for purposes of the plan. I understand that my election change request can be denied if I do not sign this form or if my request is not supported by the regulations governing permitted election changes.

**X**\_\_\_\_\_  
Account Holder Signature

Date (mm-dd-yyyy)

**X**\_\_\_\_\_  
Payroll/HR Signature

Date (mm-dd-yyyy)