HUMPHREY & PACE
BENEFIT PLANNING, INC

Cafeteria Plan & HRA Election Change Form

Required if changing benefit elections outside of Open Enrollment

Employer _____ **Last 4 of Employee SS #** XXX-XX-_____

Employee Name _____ **Daytime Phone #** _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Date of Qualifying Event: _____ **Changes will be effective the 1st of the month following the qualifying event date.**

REASON FOR ELECTION CHANGE

In the area provided below check the box next to the applicable Qualifying Event, describe the change in status which justifies the change or revocation requested on this form and complete your election changes.

- ☐ Birth or Adoption
- ☐ Change in legal marital status
- ☐ Change in number of dependents
- ☐ Change in employment status of Employee or Spouse that affects benefit eligibility
- ☐ Change in residence that affects benefit eligibility
- ☐ Entitlement to Medicare or Medicade
- ☐ FMLA
- ☐ Judgment, Decree or Court Order
- ☐ Change in coverage of spouse or dependent under their Employer's benefit plan
- ☐ Loss of Coverage Under Other Group Health Plan
- ☐ Dependent satisfies or ceases to satisfy eligibility requirements
- ☐ Significant curtailment of coverage by other Group Health Plan

The IRS Consistency Rule: *As a general rule, election changes must be consistent with and correspond to a change in the status that affects eligibility for coverage under an employer's plan.*

Brief Description of Change in Status: _____

_____

_____

Employee Pre-Tax Benefit Elections

BENEFIT DESCRIPTION	CYCLE	CURRENT DEDUCTION	REVISED ELECTION DUE TO EVENT
Dependent Care Account (DC)	Monthly	$_____	$_____
Flexible Spending Account (ME)	Monthly	$_____	$_____
Insurance Premiums for_____ (PA)	Monthly	$_____	$_____
Insurance Premiums for_____ (PA)	Monthly	$_____	$_____
Insurance Premiums for_____ (PA)	Monthly	$_____	$_____
Insurance Premiums for_____ (PA)	Monthly	$_____	$_____

700 East Main Street, Suite 107
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Phone (541) 779-5881 Fax (541) 779-5511

Employer Funded Benefit(s), IF APPLICABLE

BENEFIT DESCRIPTION	CYCLE	CURRENT BENEFIT	REVISED BENEFIT DUE TO EVENT
Cafeteria Credit (CR)	Monthly	$_____	$_____
Health Reimbursement Arrangement (HRA)	Monthly	$_____	$_____

DISCLOSURES

I hereby authorize my Employer to reduce my cash compensation as indicated above, for each pay period during the year following the date of this agreement. I understand that this will lower my gross pay, and consequently, my tax base, and my Social Security base. I further understand that my termination of employment with my Employer revokes any election to reduce my compensation. **I understand that the pre-tax deductions will be in effect for the entire plan year and cannot be revoked unless I experience an IRS Approved qualifying event that warrants a change.** If I elect participation in the FLEXIBLE SPENDING ACCOUNT OR DEPENDENT CARE ACCOUNT, I understand the following: This money must be used for expenses incurred before the end of the Plan Year or be forfeited. I may continue to submit claims up to three months after the Plan Year end for the prior year's expenses. **I further understand if my employment terminates during the Plan Year I will be given three months from the date of termination in which to submit my request for reimbursement for expenses incurred before termination.** I understand that the insurance premium(s) elected must be approved by the issuing insurance company and my insurance election(s) will only change when there is a change in the premium by the insurance company. I understand that benefits provided to me tax-free SHOULD NOT BE USED as credits or deductions ON MY PERSONAL income TAX RETURN.

Employee Signature:_____ **Date:**_____

I, the Plan Administrator have agreed to and accepted this Qualifying Event(s) and subsequent Election Change(s).

Plan Administrator Signature:_____ **Date:**_____

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