

FLEXIBLE BENEFITS PLAN CHANGE IN ELECTION FORM

(WOODBIDGE MANAGEMENT & EDUCATION SERVICES - WMES)

This form is used to change your annual election(s). To make changes to your personal data (name, address, direct deposit bank, etc.), please use the **Change In Data Form** which may be obtained online at www.flexchecks.com. Employee (participant) should complete Part I, II, and III. Employer should complete Part IV.

Company Name: _____

Employee Name: _____ Social Security: _____

Address: _____

PART I: Change in Status

I have had the following change in status (as defined in the Plan) since I signed the Election Form (check one):

- Leave of Absence and/or Layoff
Date of Leave/Layoff: _____
Date of Last Payroll Deduction: _____
Does of Leave Qualify under FMLA? Yes No
- I have taken an unpaid leave of absence.
- My spouse or dependent has taken an unpaid leave of absence.
- I have terminated employment
Date of last payroll deduction: _____ Date of termination: _____
- I have married.
- I have divorce or legally separated or my marriage has been annulled.
- My dependent (i.e., spouse, child or other dependent) has died.
- I have had a child (by birth, adoption or placement for adoption).
- My spouse or dependent has terminated employment.
- My employment status is affected by strike or lockout.
- The employment status of my spouse or dependent is affected by a strike or lockout.
- I have changed my work site.
- My spouse or dependent has had a change in work site.
- I have had the following change in employment status which affects my eligibility for benefits
Explain: _____
- My spouse or dependent has had the following change in employment status, which affects his or her eligibility for benefits. Explain: _____
- My dependent **now** satisfies the requirements for coverage due to the attainment of a specified age, student status or similar circumstance.
- My dependent **ceases** to satisfy the requirements for coverage due to the attainment of a specified age, student status or similar circumstance.
- I have changed my place of residence.
- My spouse or dependent has changed his or her place of residence.

- I am returning from an FMLA leave and elect to reinstate my election with respect to Employer's group health insurance plane [and/or the Medical Spending Account].
- My cost for dependent care services has increased or decreased and I elect to make a corresponding change under my Dependent Care Spending Account. (Note-an election change is not permitted in this situation if your dependent care provider is your relative.)
- My spouse, former spouse or dependent is enrolled in his or her employer's plan and that plan has a different 12-month election year than this Plan. My spouse, former spouse or dependent has made an election during the open enrollment period of his or her employer's plan and I elect to make an election change which is on account of, and corresponds with, the election change under the other plan. (Note-an election change is not permitted in this situation with respect to your Medical Spending Account.)
- A court order resulting from divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) has been entered regarding accident or health coverage for my child. If the order requires coverage under Employer's group health insurance plan, I elect coverage for my child. If the order requires my spouse, former spouse, or other individual to provide accident or health coverage, I elect to cancel Employer provided coverage for my child.
- I, my spouse or my dependent has become entitled to Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits) and I elect to cancel or reduce Employer-provided accident or health coverage for the affected individual(s).
- I, my spouse or my dependent that has been entitled to Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits) has lost eligibility for such coverage and I elect to begin or increase Employer provided accident or health coverage for the affected individual (s).
- Other: I feel I have a change in status NOT listed above.

Explain: _____

If I have a change in status as indicated above, I understand that I may change my election only if it is on account of, and corresponds with the change. Here are some examples:

- If I get married or have a baby I may elect to increase the number of my dependents on my group health coverage and/or increase my Medical Spending Account election for the plan year.
- If my spouse terminates employment and loses eligibility for group health coverage through his or her former employer I may elect to add my spouse to my group health coverage.
- If my child turns 13 and I am no longer eligible to obtain reimbursement for my child's dependent care under my Dependent Care Spending Account, I may elect to discontinue my election.
- If I move my place of residence and am no longer in the service area of the HMO in which I am enrolled, I may elect to switch to other group health coverage.

Exceptions to the "on account of corresponds with" rule are available where:

- Your spouse or dependent has a change in status, which causes a loss in eligibility under your group health coverage. In this situation, you may increase your pre-tax reductions to pay for the cost of their COBRA.
- If you and your spouse have a change in marital status or if your spouse or dependent has a change in employment status, your disability income benefits and/or group term life insurance benefits election(s) may be increased or decreased.

PART II: Benefit Election Changes

In accordance with the change in status described above, I elect to change my benefit election under the Plan. Please complete the following information (all account information is available at www.flexchecks.com):

Current Election Information

	Column A	Column B	Column C	Column D
Benefit	Current Annual Election	Current Per Pay Period	YTD Contributions thru ___/___/___	Reimbursements thru ___/___/___
FSA Medical				
FSA Dependent Care				

New Election Information

Benefit	New Per Pay Period Amount	X	# of Pay Periods Remaining in Plan Year	+	YTD Contributions from Column C	=	Column E
							New Annual Election (cannot be less than Column C or D above)
FSA Medical		X		+		=	
FSA DepCare		X		+		=	

PART III: Participant Representations

I understand that the change in my election, as indicated above, will be effective at the time prescribed by the plan administrator. I also understand that this election may not be changed during the remainder of the plan year (ending) unless I have another change for which federal law permits me to make a new election.

I CERTIFY THAT ALL THE INFORMATION IN THIS DOCUMENT IS TRUE. I AGREE TO SUPPLY ANY ADDITIONAL INFORMATION THAT THE PLAN ADMINISTRATOR, IN ITS DISCRETION, DETERMINES IS NECESSARY TO PROCESS MY REQUEST FOR A CHANGE IN MY BENEFIT ELECTION.

Employee's Signature: _____ Date: _____

PART IV: Employer Verification

NEW ANNUAL FSA MEDICAL \$ _____ (from Column E above)

NEW ANNUAL FSA DEPENDENT CARE \$ _____ (from Column E above)

Effective Date: _____ First payroll date in which change applies: _____

Employer's Signature: _____ Date: _____

Please return this form to:

Flexchecks, Inc. PO Box 141215, Grand Rapids, MI 49514-1215
 Phone: 616.791.7900 • Toll Free: 866.791.7900 • FAX: 616.791.7901

Note: If you are faxing this form, please be sure to send all three pages.