Notice of Change in Status and
Request to Change Employee Benefit Plan Elections

Complete this form when a change in status has occurred which affects your Hamilton College Flexible Spending Plan "Plan" elections. All changes must be due to and consistent with the change in status. **This form must be received by Human Resources within 30 days of the event causing the change in status.**

Employee name _____ Status change date _____

Phone _____

As a participant in the Plan, I am entitled to revoke my prior benefits election and enter into a new election in the event of certain changes in status. I understand that the change in my benefits election must be due to and consistent with the change in status or otherwise permitted by law and that the change must be acceptable under the Plan, and, where applicable, Section 125 of the Internal Revenue Code and/or our insurance carrier contracts.

I certify that I have incurred the following change in status:

Change in Marital/Domestic Partner Status

- □ Change in legal marital status including marriage, death of spouse, divorce, legal separation or annulment.
- □ Change in Domestic Partner Status

Change in Number of Dependents

- □ Change in the number of dependents including birth, adoption, placement for adoption or death of a dependent.

Changes in Spouse/Domestic Partner or Dependent's Eligibility

- □ Change in dependent child(ren) status in satisfying or ceasing to satisfy the eligibility requirements of the Plan, such as attainment of limiting age or student status or change in marital status.
- □ Judgment, decree or order including the imposition of a Qualified Medical Child Support Order (QMCSO).
- □ Gain or loss of Medicaid or Medicare entitlement.
- □ Entitlement to COBRA.
- □ Special requirements relating to the Family and Medical Leave Act (FMLA).

Change in Employment Status that Changes Eligibility Status

- □ Change of employment status, such as termination or commencement of employment by the employee, spouse/domestic partner or dependent child.
- □ Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse/domestic partner or dependent child, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence. The change must result in a modification of your eligibility status under the plan.
- □ Change in eligibility due to change in residency of the employee, spouse/domestic partner or dependent child.

Change in Cost or Coverage (not applicable for the healthcare spending account)

- □ Significant cost increase or decrease 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/domestic partner under other employer's plan provided that the employee, spouse/domestic partner or dependent child elects coverage under the dependent's plan.
- □ Loss of group coverage sponsored by a governmental or educational institution, including a state's children health insurance program.
- □ Dependent care provider is replaced by another.

Please change my election(s) as follows:

Following are the persons affected by the change in status:

_____ (Employee Name, if applicable)

	Name of Dependent	Relationship to Employee
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I would like to make the following coverage / election change(s)*:

	Add	Terminate
Medical Insurance	_____	_____
Dental Insurance	_____	_____
Vision Insurance	_____	_____
Healthcare Spending Account	_____	_____
Dependent Daycare Spending Account	_____	_____
Supplemental Life Insurance	_____	_____

Check here if you would like a life insurance beneficiary change form: _____

I understand that I will be required to provide documentation for the changes I have requested, that election changes must comply with the Plan, and that the Administrator has sole discretion to make this determination. If I am requesting a change to cancel or reduce coverage because (a) I or my family member have become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or have become entitled to 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. If my request is denied, I understand that I will have to appeal the decision within the time specified in the Summary Plan Description.

If applicable, send the necessary forms for change in coverage and/or COBRA notice to:

_____
Name of Employee or Qualified Beneficiary

_____
Address City, State, Zip Code

_____ _____
Employee signature Date

Accepted and agreed to by:

_____ _____
Human Resources Representative Date

***Important Note:** Due to Internal Revenue Code Section 125 (which governs Plan elections), a change in status may not always allow you to change your pre-tax election. The status change typically must impact your eligibility for benefits or the eligibility of your spouse or dependents. In addition, your requested election change generally must be consistent with your change in status. For example, if the status change is marriage, consistent enrollment changes would include addition of coverage for the newly eligible dependent.