Section 125 Employee Change Form **Employer: Tusculum College** **Plan Year: Apr 1, 2017 – Mar 31, 2018**

INFO

Employee Name (Last, First, MI): _____

Social security number: _____

*Enter address info below **ONLY** if changing address:*

Address Line 1: _____ City: _____ State: _____ Zip: _____

Please enter information in the section below **ONLY** if applying for a Change or Termination to current elections:

CHANGE OR TERM

If changing elections, mark the Change checkbox not the Termination checkbox.

Mark the Termination checkbox to drop coverage. NOTE – Termination date usually refers to the last date worked or covered by the plan. If the termination date is during the middle of a payroll period the final pay deduction may be prorated.

☐ **CHANGE -** Effective _____, change elections as specified in the **attached** new Election Agreement

☐ **TERMINATION -** Terminate the following under the Plan as specified below due to Termination date of _____:

☐ **Group Premium Payment for:**

Medical	Dental	Vision
For employee ☐	For employee ☐	For employee ☐
For spouse ☐	For spouse ☐	For spouse ☐
For dependent(s) ☐ _____	For dependent(s) ☐ _____	For dependent(s) ☐ _____

☐ **Health FSA → If termination, indicate total withheld to date by time of termination: _$_____**

REASON

The reason for election request is based on the Event(s) checked below. Generally cannot be retroactive:

☐ Change in marital status due to:

☐ **Marriage** ☐ **Divorce** ☐ **Legal Separation** ☐ **Annulment** ☐ **Spouse's Death**

☐ Increase in number of dependents due to:

☐ **Birth** ☐ **Adoption** ☐ **Dependent satisfies coverage requirements** ☐ **Marriage**

☐ Decrease in number of dependents due to:

☐ **Placement for adoption** ☐ **Death** ☐ **Dependent ceases to satisfy coverage requirements** ☐ **Marriage**

☐ **Divorce** ☐ **Legal Separation**

☐ Change in status of employment of participant, spouse, or dependent

☐ **Termination** ☐ **Commencement of employment** ☐ **FMLA** ☐ **non-FMLA** ☐ **Return from FMLA** ☐ **Return from non-FMLA**

☐ **Change in employment status (hourly to salary, union to non-union, full-time to part-time, etc.) that affects rights to benefits**

☐ Residence change of participant, spouse, or dependent that affects eligibility

☐ Change in participant benefits or benefit eligibility or that of spouse or dependent

☐ Medicare or Medicaid entitlement for participant, spouse, or dependent

☐ Loss of Medicare or Medicaid entitlement for participant, spouse, or dependent

☐ Other Event (Please describe based on list of events in Plan document)_____

I understand that the Plan Administrator may require proof of this Event. If I am requesting a change due to a change in eligibility for other benefits, I certify that I have already obtained or am in the process of obtaining such coverage.
I hereby elect the change(s) indicated and certify that this change is consistent with the change in status noted above.

Participant signature_____ Date_____

Accepted by:

Administrator signature_____ Date _____

Print Form *Submit Form* *Reset Form*

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