

Se	ction 125 Employee Change Form Empl	oyer: Tusculum College	Plan Year: Apr 1, 2018 – Dec 31, 2018	
	Employee Name (Last, First, MI):			
I N F O	Social security number:			
	Enter address info below ONLY if changing address:			
	Address Line 1:	City:	State: Zip:	
DI-				
Please enter information in the section below <b>ONLY</b> if applying for a Change or Termination to current elections:  If changing elections, mark the Change checkbox not the Termination checkbox.			nt elections:	
_	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.			
H	□ CHANGE - Effective, change elections as specified in the attached new Election Agreement			
A N G	□ <b>TERMINATION -</b> Terminate the following under the Plan as specified below due to Termination date of:			
Ē	□ Group Premium Payment for:			
0	Medical	Dental	Vision	
R	For employee	For employee	For employee	
_	For spouse □ For dependent(s) □	For spouse  For dependent(s)	For spouse  For dependent(s)	
T E	Tor dependent(s)			
R M ☐ Health FSA → If termination, indicate total withheld to date by time of termination: _\$				
			_\$	
The reason for election request is based on the Event(s) checked below. Generally cannot be retroactive:			etroactive:	
REAS	□ 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 (hour	☐ 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			
O N	☐ Medicare or Medicaid entitlement for participant, spouse, or dependent			
N	□ 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	Da	ate	
	Accepted by:			
	Administrator cianaturo	Da	nto.	