

## Change of Election

**For Employer use only. Do not send to FlexSystem.**

A change of election(s) must be (a) relevant to the circumstance causing the change and (b) be made within 30 days of the qualifying event. This form is for internal communication only. Please notify FlexSystem of changes using the Payroll Verification Report (PVR) located on-line at [www.exploretasc.com](http://www.exploretasc.com). Click in the appropriate cell of the Participant's account and make the change. Doing this will permanently change the elected amount.

Participant Name: \_\_\_\_\_ Participant ID #: \_\_\_\_\_

Effective date of change: \_\_\_\_\_ First payroll affected by change: \_\_\_\_\_

### TYPE OF CHANGE

I hereby request a change in my benefit election(s) as follows:

**Medical Expenses** (out-of-pocket)      A. Change payroll deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_

B. Revised annual election      \$ \_\_\_\_\_  
(To determine new annual election, take your year-to-date deductions made at the old rate plus your revised deductions at the new rate for the remaining pay periods in the Plan year.)

**106P-Independent Insurance** (premiums billed to your home)      Change payroll deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_

**Dependent/DayCare Account**      Change payroll deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_

**Group Insurance Premium** (employer receives the bill)      Change payroll deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_

**Transportation Benefit**      Change payroll deduction from \$ \_\_\_\_\_ to \$ \_\_\_\_\_  
(Below reasons for change do not apply to the Transportation Benefit)

### REASON FOR CHANGE

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Change in Legal Marital Status*                                   | <input type="checkbox"/> Change in the Cost of Coverage*      | <input type="checkbox"/> Addition or Elimination of Benefit Package                             |
| <input type="checkbox"/> Change in Number of Dependents                                    | <input type="checkbox"/> HIPAA Special Enrollment Rights      | <input type="checkbox"/> Entitlement to Medicare or Medicaid                                    |
| <input type="checkbox"/> Change in Employment Status                                       | <input type="checkbox"/> Judgement, Decree or Order*          | <input type="checkbox"/> Change in Coverage of Spouse or Dependent Under Other Employer's Plan* |
| <input type="checkbox"/> Dependent Satisfies or Ceases to Satisfy Eligibility Requirements | <input type="checkbox"/> FMLA                                 |   |
| <input type="checkbox"/> Change in Residence   | <input type="checkbox"/> COBRA                                |   |
|  | <input type="checkbox"/> Significant Curtailment of Coverage* |   |

\* Changes to insurance costs only qualify for a corresponding change to the insurance election and/or coverage. Note: See Summary Plan Description for further explanation of these events.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Retain this form for your records and communicate changes of election to FlexSystem using the Payroll Verification Report located on-line at [www.exploretasc.com](http://www.exploretasc.com).**

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