Envision Healthcare
Change in Election Form / Salary Reduction Agreement

Company Name: _____

Employee Name: _____

Employee Address: _____

City: _____ State: _____Zip Code: _____

Election Change applies to (check all that apply):

☐ Health FSA Benefits

☐ Dependent Care (DCAP) Benefits

☐ Transit / Parking Commuter Benefits

Part I.

Election Change Requested (check A or B):

A). ☐ **Revocation of an existing election**

Effective _____, I wish to REVOKE my existing election under my company's Salary Reduction Plan for the above indicated benefit plan (s).

B). ☐ **New Election**

Effective _____, I hereby make a new election as specified on the attached Election form/ Salary Reduction Agreement for the above indicated benefit plan (s).

Part II.

The Change in Election Event(s) on which my request is based is/are:

Check applicable box to indicate the Change in Election Event(s) that apply to your situation. Election changes generally cannot be retroactive and must be consistent with the Change in Election Event, as described at the end of this form.

A) Change in Status (applies to Health FSA, DCAP, Transit/Parking Benefits; for Health FSA Benefits, may seek to increase, cancel, or reduce coverage)

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1. **Change in Martial Status**

   ☐ Marriage

   ☐ Divorce or annulment

   ☐ Legal separation

   ☐ Death of spouse

2. **Change in Number of Tax Dependents**

   ☐ Birth

   ☐ Adoption or placement for adoption

   ☐ Death of dependent

3. **Change in Employment Status that affects Eligibility**

   ☐ Termination of Employment (change affects you / spouse)

   ☐ Commencement of Employment (change affects you / spouse)

   ☐ Part time to Full time (change affects you / spouse)

   ☐ Full time to Part time (change affects you / spouse)

   ☐ Other (provide details): _____

4. **Change in Dependent's Eligibility Under Employer's Plan**

   ☐ Lost eligibility (such as age, student status, marital status)

   ☐ Gained eligibility (such as age, student status, marital status)

5. ☐ **Change in Resident Affecting Eligibility** (change affects you / spouse)

B) Change in Dependent Care (DCAP) Cost / Provider (applies to DCAP Benefits only)

   ☐ Significant cost increase or decrease in cost of coverage

   ☐ Changed dependent care provider

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C) Change in Transit / Parking Status (election is irrevocable once the pay period in which the salary would be reduced commences, it is also irrevocable once the benefit period has commenced)

☐ Significant cost increase or decrease in cost

☐ No longer incur commuter expenses

D) Other Event (see your Summary Plan Description for the list of other events that permit a change in election)

☐ **Other: _____**

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

If approved, I hereby elect the change(s) noted on the attached Election form / Salary Reduction Agreement and attest that the change is made on account of and is consistent with the change in election event.

Employee's Signature_____Date_____

Accepted and Agreed to:

Administrator's Signature_____Date_____