

**MOTT COMMUNITY COLLEGE
HEALTHCARE AND DEPENDENT CARE
EXPENSE REIMBURSEMENT PLAN
CHANGE OF ELECTION FORM**

Name: _____

Last Four Digits of SS#: _____

I understand that federal regulations prohibit me from changing the election that I have made after the beginning of the Plan Year, except because of a change in family circumstances. I also understand that my employer may request documentation or verification of this change. I hereby certify that I have incurred the following change in family status:

- Marriage
- Divorce
- Birth or adoption of a child
- Placement of a child for adoption
- Death of my spouse or child
- A significant change in medical benefits or premiums due to my spouse's employment
- A significant change in medical benefits or premiums attributable to my employment
- A judgment, decree, or order (e.g. a QDRO) requires me to now provide coverage for my dependent child
- A change in eligibility for Medicare or Medicaid for myself, my spouse or my dependent
- My spouse's unpaid leave of absence
- Termination or commencement of my spouse's employment
- Change of my spouse's employment status from full to part time or vice versa
- Change of my employment status from full to part time or vice versa

- Other: _____

Date event occurred _____. (This form must be completed within 30 days of the event.)

New Coverage Level

\$ _____ **New (annual) amount of Healthcare reimbursement contribution.**

\$ _____ **New (annual) amount of Dependent Care reimbursement contribution.**

If you are adding dollars to either account, the amount will be prorated among your remaining pay periods. If you are increasing an already existing contribution, the new amount will be reduced by the amount already deducted from your paycheck. Remember, if you change your coverage level to \$0, while no further reductions will be made, you will only be reimbursed for eligible expenses incurred prior to the date your coverage ends.

I hereby certify that the information furnished in this form is true and complete to the best of my knowledge. I understand that these new benefit elections will remain in effect through the last day of the Plan Year, unless I become eligible for another change in election.

Employee's signature: _____

Date: _____

Accepted and agreed to by: _____

Date: _____