

**REQUEST FOR MID-YEAR REVOCATION  
OR CHANGE IN BENEFIT ELECTION**

**PART 1 – EMPLOYEE INFORMATION** (*Must Be Completed – Please Print*)

Employee's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Home Address \_\_\_\_\_ Group Name (Employer) \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ Daytime Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_

**PART 2 – STATUS CHANGE** (*YOU, YOUR SPOUSE, OR DEPENDENT MUST HAVE EXPERIENCED ONE OF THE FOLLOWING STATUS CHANGES WITHIN THE PAST 30 DAYS*)

<i>Status Change (check one)</i>	<i>Date of Status Change</i>	<i>Name and Relationship of Person Experiencing Status Change</i>	<i>Documentation You <b>Must</b> Attach With This Request</i>
<input type="checkbox"/> Marriage			Copy of Marriage License
<input type="checkbox"/> Divorce			Copy of Divorce Decree
<input type="checkbox"/> Legal Separation/Annulment			Copy of Court Order
<input type="checkbox"/> Birth			Copy of Birth Certificate
<input type="checkbox"/> Adoption			Copy of Adoption Papers
<input type="checkbox"/> Gain or Loss of Custody			Copy of Custody Agreement
<input type="checkbox"/> Death of Spouse or Dependent			Copy of Death Certificate
<input type="checkbox"/> Move Out of Coverage Area			Letter from Employer
<input type="checkbox"/> Change in Employment Status			Letter from Employer
<input type="checkbox"/> Termination of Employment			Copy of Termination Notice
<input type="checkbox"/> Retirement of Spouse			Letter from Employer
<input type="checkbox"/> Medicare Eligibility			Copy of Medicare Card
<input type="checkbox"/> Loss of Dependent's Eligibility <i>(due to age or student status)</i>			Copy of Birth Certificate

**PART 3 – DESIRED CHANGE** (*YOUR REQUEST MUST BE APPROPRIATE AND CONSISTENT WITH THE STATUS CHANGE YOU CHECKED ABOVE*)

<i>Check All That Apply</i>	<i>Change From</i>	<i>Change To</i>	<i>Check All That Apply</i>	<i>Change From</i>	<i>Change To</i>
<input type="checkbox"/> Group Medical Insurance			<input type="checkbox"/> Medical Spending Account		
<input type="checkbox"/> Group Dental Coverage			<input type="checkbox"/> Dependent Care Account		
<input type="checkbox"/> Group Vision Coverage			<input type="checkbox"/> Group Term Life Insurance		
<input type="checkbox"/> Group Cancer Insurance			<input type="checkbox"/> Other (describe)		

**PART 4 – EMPLOYEE'S SIGNATURE** (*Required*)

I certify that the information provided on this Application is accurate and correct, that I have read the instructions for completion of this Application, and that I have attached the documentation required to substantiate the status change indicated above. I further understand that, if approved, my election change will not be effective retroactively but will become effective on the first pay period following the date of approval.

**X** \_\_\_\_\_ Date \_\_\_\_\_

Please Read the Instruction Page for Important Information

**FOR ADMINISTRATIVE USE ONLY**

Recommendation:  For Approval  For Denial By: \_\_\_\_\_ for EBS/Atlanta Date: \_\_\_\_\_  
 Recommendation:  Accepted  Rejected By: \_\_\_\_\_ for Employer Date: \_\_\_\_\_

*Please Read Carefully*  
**INSTRUCTIONS FOR COMPLETING THE  
REQUEST FOR MID-YEAR REVOCATION  
OR CHANGE IN BENEFIT ELECTION FORM**

**Federal Regulations**

Your Employer's flexible benefits program (also known as a "cafeteria benefits plan") is governed by the Department of the Treasury, Internal Revenue Service (IRS). This includes your pre-tax insurance premiums, Medical Flexible Spending Account and/or Dependent Care Account. Federal Regulations prohibit the revocation or change to elections after the beginning of a Plan Year unless you experience a "status change" recognized by the Internal Revenue Service.

**Who Should File A Request**

Only employees who have experienced one of the status changes listed on the "Request For Mid-Year Revocation or Change In Benefit Election Form" should file a request.

**When You Should File A Request**

You should file a request to make any desired change in your elections within 30 days of experiencing an eligible status change.

**Completion of the Request Form**

- You must complete **all** applicable information on the Request Form.
- You **must** complete **Part 1 – Employee Information** and you **must** sign and date your Request Form.
- **Proper documentation to substantiate your request must be attached to your Request Form.**
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- Make sure your request is appropriate and consistent with the status change experienced.. See below -

**EXAMPLES OF ACCEPTABLE ELECTION CHANGES**

**STATUS CHANGE**

**ACCEPTABLE ELECTION CHANGE**

- |  |   |
|--|---|
| • <b>Marriage</b>                                | <b>Change in Affected insurance Coverages</b>   |
| • <b>Divorce/Legal Separation/Annulment</b>      | <b>Change in Affected insurance Coverages</b>   |
| • <b>Birth/Adoption/Custody of Child</b>         | <b>Change in Health insurance Coverage<br/>Establish Dependent Care Account<br/>Increase Dependent Care Account Contribution</b>                |
| • <b>Death of Spouse or Dependent</b>            | <b>Change in Affected insurance Coverages<br/>Establish Dependent Care Account<br/>Increase or Decrease Dependent Care Account Contribution</b> |
| • <b>Change in Employment (by you or spouse)</b> | <b>Change in Affected insurance Coverages</b>   |
| • <b>Retirement of Spouse</b>                    | <b>Change in Affected insurance Coverages</b>   |
| • <b>Medicare Eligibility</b>                    | <b>Change in Health Insurance Coverage</b>  |

**When Your Request Will Be Effective**

Your request will become effective on the first pay period following the date it is approved by EBS/Atlanta and accepted by your Employer. Requests may not be made retroactive.

**About Medical Flexible Spending Accounts**

Your Employer's plan does not permit mid-year changes to a Medical Flexible Spending Account..

**Mail Your Completed Request With Supporting Documentation To:**

**EBS/Atlanta  
2500 Northwinds Parkway  
Suite 375  
Alpharetta, GA 30009**

**Or Fax Your Completed Request With Supporting Documentation To:**

**EBS/Atlanta  
(770) 569-0211**

**Questions? Call (77) 569-0080 or, toll-free, 1-800-647-3709 or e-mail your question to [flex@ebsatlanta.com](mailto:flex@ebsatlanta.com)**