APPLICATION TO CHANGE YOUR CAFETERIA PLAN ELECTION MID-YEAR

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Under limited circumstances, you ***may*** be permitted to change your pre-tax health insurance election(s) during the plan year. Following are the three (3) conditions that must be met in order for your request to be approved:

(1) You must experience an event that permits you to make the change you are requesting;

(2) Your request must be on account of and consistent with the permissible event; and,

(3) You must submit your request to your employer within 30 days of the date the event occurred.

The above conditions apply to all health insurance that you pay for with **tax-free** dollars through payroll, including (if offered by your employer) any voluntary & supplemental policies for which you pay the entire premium (e.g. AFLAC, Colonials, American Fidelity, etc.).

The above conditions DO NOT apply to tax-free tax payroll contributions made to an HSA (Health Savings Account). Generally, you are free to change the amount you contribute to an HSA during the plan year. DO NOT complete this form if you just want to change the amount you contribute to an HSA. Contact your employer for the appropriate HSA change form. Note: California charges state taxes on HSA contributions.

Your request to change an election is NOT guaranteed. If your request meets the conditions and is approved by your employer, the change will take effect on the next available payroll. A change of election may not be made effective retroactively, regardless of the date you request.

You ARE REQUIRED to complete a separate form for EACH election you wish to change. For example, if you wish to change your medical insurance election and your dental insurance election, you must complete two forms. Write clearly and complete all fields. Use extra paper if needed.

1	ENTER THE NAME OF YOUR **EMPLOYER** Berkeley USD		ENTER THE DATE YOU WANT THE CHANGE TO BE EFFECTIVE (mm/dd/yyyy)		
2	ENTER YOUR FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DAY TIME PHONE NUMBER (with area code)	
3	ENTER YOUR MAILING ADDRESS		CITY	STATE	ZIP CODE
4	ENTER THE BENEFIT YOU WISH TO CHANGE – **LIMIT ONE CHANGE PER FORM** (e.g. "UHC Medical", "Kaiser Medical", "Delta Dental", "AFLAC Cancer", Health FSA, Dependent Care FSA, etc.)				
5	ENTER YOUR **CURRENT** COVERAGE TIER (e.g. "Not Enrolled", "Single", "EE+1", "Family")		ENTER THE COVERAGE TIER THAT YOU ARE **REQUESTING** (e.g. "Drop Coverage", "Single", "EE+1", "Family")		
6	ENTER THE AMOUNT OF YOUR **CURRENT** PAYROLL DEDUCTION $		ENTER THE AMOUNT OF YOUR **REQUESTED** PAYROLL DEDUCTION $		

7 **SELECT THE EVENT THAT CAUSED YOU TO MAKE YOUR REQUEST** (please note that some of these events will NOT apply to the coverage you wish to change or may not be allowable events under your employer's pre-tax plan)**:**

- ☐ Change of legal marital status
- ☐ Change in the number of your dependents
- ☐ Change of employment status of spouse/dependent (that results in a loss of eligibility)
- ☐ Reduction in your work hours (from full-time to less than 30 per week)
- ☐ Significant change of cost for the benefit listed
- ☐ Significant reduction of coverage under the benefit listed
- ☐ Spouse's benefits renewed at their employer
- ☐ Change in residence (that results in a loss of eligibility under an HMO)
- ☐ Addition of a new benefit or a new health plan option at your work
- ☐ Loss of coverage under a governmental or educational institution health plan
- ☐ Dependent satisfies (or ceases to satisfy) dependent eligibility requirement
- ☐ HIPAA special enrollment
- ☐ Legal Judgment, Decree or Order (including QMCSO's)
- ☐ Gain or loss of entitlement to Medicare or Medicaid
- ☐ Enrollment in a qualified health plan through the Health Insurance Marketplace
- ☐ Other: Describe

8	EXPLAIN THE EVENT THAT YOU CHECKED ABOVE IN DETAIL:				
9	ENTER THE DATE THE EVENT LISTED ABOVE OCCURRED: / /				
10	EXPLAIN HOW YOUR REQUEST TO CHANGE YOUR ELECTION IS "**ON ACCOUNT OF AND CONSISTENT WITH**" YOUR EVENT:				
11	**EMPLOYEE CERTIFICATION:** I, the undersigned, certify that all information listed on this form is true & correct to the best of my knowledge. I understand that my request is not guaranteed and must be approved by my employer. I understand that my request may not become effective until the first pay period after approval. I understand that if I knowingly falsify information, it may result in my being banned from participation or terminated from employment. I agree to remunerate my employer for any expenses incurred as a result of my knowingly falsifying information. Further, I understand that I may be asked to provide proof of my event.				
12	**EMPLOYEE** SIGNATURE	DATE	EMAIL ADDRESS		
13	**SIGNATURE OF EMPLOYER REPRESENTATIVE AUTHORIZING THIS CHANGE**		DATE	DATE OF HIRE	
14	**COMPLETED BY EMPLOYER:** ENTER THE PAY DATE THE NEW ELECTION WILL BE EFFECTIVE (IF APPROVED):				

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