

APPLICATION TO CHANGE YOUR CAFETERIA PLAN ELECTION MID-YEAR BASIC pacific (formerly CBA)

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, Colonial, 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	ENTER THE DATE YOU WANT THE CHANGE TO BE EFFECTIVE (mm/dd/yyyy)				
2	ENTER YOUR FULL NAME	ENTER YOUR SOCIAL SECURITY NUMBER	ENTER YOUR 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): <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Change of legal marital status <input type="checkbox"/> Change in the number of your dependents <input type="checkbox"/> Change of employment status of spouse/dependent (that results in a loss of eligibility) <input type="checkbox"/> Reduction in your work hours (from full-time to less than 30 per week) <input type="checkbox"/> Significant change of cost for the benefit listed <input type="checkbox"/> Significant reduction of coverage under the benefit listed <input type="checkbox"/> Spouse's benefits renewed at their employer <input type="checkbox"/> Change in residence (that results in a loss of eligibility under an HMO) </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Addition of a new benefit or a new health plan option at your work <input type="checkbox"/> Loss of coverage under a governmental or educational institution health plan <input type="checkbox"/> Dependent satisfies (or ceases to satisfy) dependent eligibility requirement <input type="checkbox"/> HIPAA special enrollment <input type="checkbox"/> Legal Judgment, Decree or Order (including QMCSO's) <input type="checkbox"/> Gain or loss of entitlement to Medicare or Medicaid <input type="checkbox"/> Enrollment in a qualified health plan through the Health Insurance Marketplace <input type="checkbox"/> Other: Describe </td> </tr> </table>				<input type="checkbox"/> Change of legal marital status <input type="checkbox"/> Change in the number of your dependents <input type="checkbox"/> Change of employment status of spouse/dependent (that results in a loss of eligibility) <input type="checkbox"/> Reduction in your work hours (from full-time to less than 30 per week) <input type="checkbox"/> Significant change of cost for the benefit listed <input type="checkbox"/> Significant reduction of coverage under the benefit listed <input type="checkbox"/> Spouse's benefits renewed at their employer <input type="checkbox"/> Change in residence (that results in a loss of eligibility under an HMO)	<input type="checkbox"/> Addition of a new benefit or a new health plan option at your work <input type="checkbox"/> Loss of coverage under a governmental or educational institution health plan <input type="checkbox"/> Dependent satisfies (or ceases to satisfy) dependent eligibility requirement <input type="checkbox"/> HIPAA special enrollment <input type="checkbox"/> Legal Judgment, Decree or Order (including QMCSO's) <input type="checkbox"/> Gain or loss of entitlement to Medicare or Medicaid <input type="checkbox"/> Enrollment in a qualified health plan through the Health Insurance Marketplace <input type="checkbox"/> Other: Describe
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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		
13	SIGNATURE OF EMPLOYER REPRESENTATIVE AUTHORIZING THIS CHANGE			DATE		
14	COMPLETED BY EMPLOYER: ENTER THE PAY DATE THE NEW ELECTION WILL BE EFFECTIVE (IF APPROVED):					

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