The BESTflex Plan
Employee Benefits Corporation

Permitted Election Change Form

Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126** | 608 831 8445
E-mail support: **employerservices@ebcflex.com**

This form is used to notify us that an employee is making a mid-year change to a prior election due to a qualifying event.

Notification of an election change must be made no later than 30 days after the qualifying event.

The change could:

- Create an election when no prior election existed, or
- Increase or decrease a prior election, or
- Make an election after return from an unpaid leave that resulted in loss of eligibility, or
- Terminate (revoke) an election

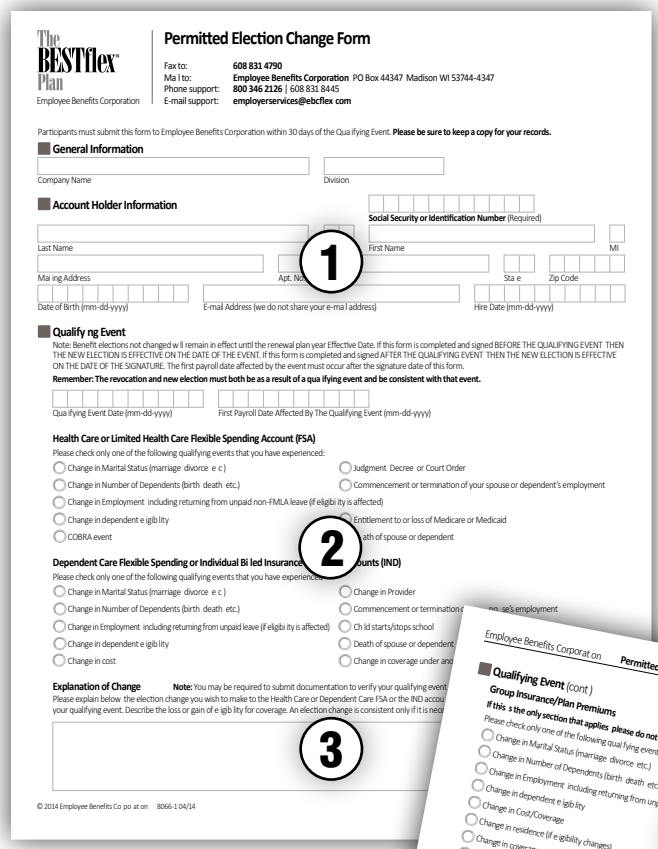
For employees who did not previously have an election but experience an event that allows them to make an election, please be sure to complete Account Holder Information (1).

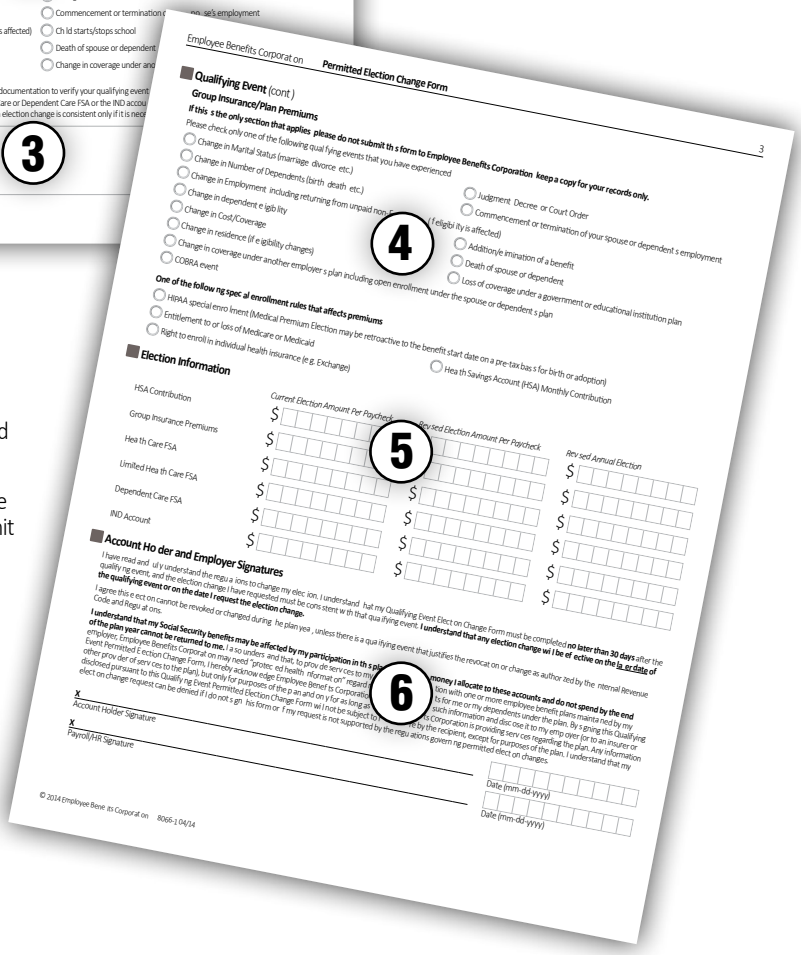
The change in election is effective the date the form is signed or the date of the event, whichever is later.

Example: Beth gets married May 5th and completes (signs) the form to increase her Health Care FSA election May 20th. Her requested change is effective May 20th.

Example: Joe fills out and signs the form to request an increase in his Health Care FSA election on August 15th in anticipation of the birth of a child. The child is born August 26th. Joe completes the form (provides the birth date) and the requested change is effective August 26th.

Example: Joe completes and signs the form to request an increase in his Health Care FSA on September 15th due to the birth of a child. The child was born August 26th. Joe's requested change is effective September 15th.





Qualifying Event

Check the appropriate box for the event that occurred providing for the requested election change for the Health Care FSA, Dependent Care FSA or Individual Billed Premium Account (IND) (2).

Provide a short explanation of the qualifying event and the rationale for the requested election change (3).

Check the appropriate box for the event that allows for the requested election change for the Group Insurance Premiums. If this is the only section that applies, do not submit this form to Employee Benefits Corporation. Simply keep a copy of the form for your records (4).

Election Information

Complete the election change amounts for each affected account (5).

Changes in the accounts election amount result in a "blended" amount of coverage for the plan year and a "blended" payroll deduction from the effective date of the change to the plan year end. The newly elected amount must result in a payroll deduction going forward and cannot be less than expenses already reimbursed.

Example: Mary requests an increase in her Health Care FSA election from $600 to $1,400 due to her marriage on May 1. Assume this is a calendar year plan, deductions are taken monthly and Mary had been reimbursed $400 prior to her change in election. Mary had $200 deducted prior to the change ($50/month X 4 months). Therefore, in the remaining 8 months, she will have $1,200 deducted ($1,400 election - $200 deducted prior to change). Mary has $1,000 of coverage available after the change ($1,400 new election - $400 prior reimbursement).

Example: Beth had a $1,200 Health Care FSA election prior to taking an unpaid non-FMLA leave. Assume this is a calendar year plan, deductions are taken monthly, the leave began May 1 and Beth had been reimbursed $700 prior to her leave. Upon her return August 1 (3 months later), Beth elects $900 for the remainder of the year. Beth had $400 deducted prior to her leave, so she must have $500 deducted from August 1 to December 31. Beth has $200 available for reimbursement for the remainder of the year ($900 new election - $700 prior reimbursements).

Account Holder and Employer Signatures

Sign and date the form (6). Then upload the form through your secure employer portal page or fax it to Employee Benefits Corporation for immediate processing.

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Participants must submit this form to Employee Benefits Corporation within 30 days of the Qualifying Event. **Please be sure to keep a copy for your records.**

General Information

Marquette University
Company Name

Division

Account Holder Information

Social Security or Identification Number (Required)

Last Name | Suffix | First Name | MI

Mailing Address | Apt. No. | City | State | Zip Code

Date of Birth (mm-dd-yyyy) | E-mail Address (we do not share your e-mail address) | Hire Date (mm-dd-yyyy)

Qualifying Event

Note: Benefit elections not changed will remain in effect until the renewal plan year Effective Date. If this form is completed and signed BEFORE THE QUALIFYING EVENT, THEN THE NEW ELECTION IS EFFECTIVE ON THE DATE OF THE EVENT. If this form is completed and signed AFTER THE QUALIFYING EVENT, THEN THE NEW ELECTION IS EFFECTIVE ON THE DATE OF THE SIGNATURE. The first payroll date affected by the event must occur after the signature date of this form.

Remember: The revocation and new election must both be as a result of a qualifying event and be consistent with that event.

Qualifying Event Date (mm-dd-yyyy) | First Payroll Date Affected By The Qualifying Event (mm-dd-yyyy)

Health Care or Limited Health Care Flexible Spending Account (FSA)

Please check only one of the following qualifying events that you have experienced:

- ◯ Change in Marital Status (marriage, divorce, etc.)
- ◯ Change in Number of Dependents (birth, death, etc.)
- ◯ Change in Employment, including returning from unpaid non-FMLA leave (if eligibility is affected)
- ◯ Change in dependent eligibility
- ◯ COBRA event
- ◯ Judgment, Decree, or Court Order
- ◯ Commencement or termination of your spouse or dependent's employment
- ◯ Entitlement to or loss of Medicare or Medicaid
- ◯ Death of spouse or dependent

Dependent Care Flexible Spending or Individual Billed Insurance Premium Accounts (IND)

Please check only one of the following qualifying events that you have experienced:

- ◯ Change in Marital Status (marriage, divorce, etc.)
- ◯ Change in Number of Dependents (birth, death, etc.)
- ◯ Change in Employment, including returning from unpaid leave (if eligibility is affected)
- ◯ Change in dependent eligibility
- ◯ Change in cost
- ◯ Change in Provider
- ◯ Commencement or termination of your spouse's employment
- ◯ Child starts/stops school
- ◯ Death of spouse or dependent
- ◯ Change in coverage under another employer's plan

Explanation of Change

Note: You may be required to submit documentation to verify your qualifying event.

Please explain below, the election change you wish to make to the Health Care or Dependent Care FSA or the IND account and why the requested change is consistent with your qualifying event. Describe the loss or gain of eligibility for coverage. An election change is consistent only if it is necessary or appropriate as a result of the qualifying event.

Qualifying Event (cont.)

Group Insurance/Plan Premiums

If this is the only section that applies, please do not submit this form to Employee Benefits Corporation; keep a copy for your records only.

Please check only one of the following qualifying events that you have experienced:

- ◯ Change in Marital Status (marriage, divorce, etc.)
- ◯ Change in Number of Dependents (birth, death, etc.)
- ◯ Change in Employment, including returning from unpaid non-FMLA leave (if eligibility is affected)
- ◯ Change in dependent eligibility
- ◯ Change in Cost/Coverage
- ◯ Change in residence (if eligibility changes)
- ◯ Change in coverage under another employer's plan including open enrollment under the spouse or dependent's plan
- ◯ COBRA event
- ◯ Judgment, Decree, or Court Order
- ◯ Commencement or termination of your spouse or dependent's employment
- ◯ Addition/elimination of a benefit
- ◯ Death of spouse or dependent
- ◯ Loss of coverage under a government or educational institution plan

One of the following special enrollment rules that affects premiums

- ◯ HIPAA special enrollment (Medical Premium Election may be retroactive to the benefit start date on a pre-tax basis for birth or adoption)
- ◯ Entitlement to or loss of Medicare or Medicaid
- ◯ Right to enroll in individual health insurance (e.g. Exchange)
- ◯ Health Savings Account (HSA) Monthly Contribution

Election Information

	Current Election Amount Per Paycheck	*Revised Election Amount Per Paycheck*	*Revised Annual Election*
HSA Contribution:	$	$	$
Group Insurance Premiums:	$	$	$
Health Care FSA:	$	$	$
Limited Health Care FSA:	$	$	$
Dependent Care FSA:	$	$	$
IND Account:	$	$	$

Account Holder and Employer Signatures

I have read and fully understand the regulations to change my election. I understand that my Qualifying Event Election Change Form must be completed **no later than 30 days** after the qualifying event, and the election change I have requested must be consistent with that qualifying event. **I understand that any election change will be effective on the later date of the qualifying event or on the date I request the election change.**

I agree this election cannot be revoked or changed during the plan year, unless there is a qualifying event that justifies the revocation or change as authorized by the Internal Revenue Code and Regulations.

I understand that my Social Security benefits may be affected by my participation in this plan and that any money I allocate to these accounts and do not spend by the end of the plan year cannot be returned to me. I also understand that, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, Employee Benefits Corporation may need "protected health information" regarding coverage or benefits for me or my dependents under the plan. By signing this Qualifying Event Permitted Election Change Form, I hereby acknowledge Employee Benefits Corporation will obtain and use such information and disclose it to my employer (or to an insurer or other provider of services to the plan), but only for purposes of the plan and only for as long as Employee Benefits Corporation is providing services regarding the plan. Any information disclosed pursuant to this Qualifying Event Permitted Election Change Form will not be subject to redisclosure by the recipient, except for purposes of the plan. I understand that my election change request can be denied if I do not sign this form or if my request is not supported by the regulations governing permitted election changes.

X _____ Date (mm-dd-yyyy)

Account Holder Signature

X _____ Date (mm-dd-yyyy)

Payroll/HR Signature

