GUARDIAN®

SECTION 125 ELECTION CHANGE FORM

FlexPlan

Employer Name_____ Guardian Group Policy Number G-_____

Employee Name _____

Employee Mailing Address _____

Employee's E-mail Address _____

SSN or Member ID _____ Daytime Phone No. _____

FSA Accounts: Last Contribution Date _____ Year To Date Contribution $ _____

Check Applicable Box

☐ **REPLACEMENT OF AN EXISTING ELECTION WITH NEW ELECTION**
I hereby revoke my existing election under the Cafeteria Plan on ___/___/___., and elect benefits under the Plan as specified in the attached Application and Election Form.

☐ **REVOCATION OF AN EXISTING ELECTION WITHOUT NEW ELECTION**
I hereby revoke my existing election under the Cafeteria Plan on ___/___/___.

☐ **ELECTION TO PARTICPATE**
I hereby elect to participate in the Cafeteria Plan, and elect benefits under the Plan as specified in the attached Application and Election Form.

Check the appropriate box to indicate a Change in Status or a Change in Cost or Coverage. One or more of the following events listed below may qualify you to change your coverage election during the Plan Year. Changes cannot be retroactive and must be made on account of and conform with the events indicated. As a general rule, the consistency requirement will not generally be met for a Change in Status Event unless the event affects eligibility for the coverage sought to be changed under this Plan (or an employer-provided plan of your spouse or dependent). The Plan Administrator has final discretion to determine whether the eligibility requirement has been satisfied.

Change In Status

☐ Change in Marital Status
☐ Marriage ☐ Divorce/Annulment ☐ Separation
☐ Death of Spouse

☐ Change in # of Tax Dependents
☐ Birth ☐ Adoption ☐ Death of Dependent

☐ Change in Employment Status

Termination of Employment	☐ EE	☐ Spouse
Commencement of Employment	☐ EE	☐ Spouse
Part-Time / Full-Time	☐ EE	☐ Spouse
Strike or Lock Out	☐ EE	☐ Spouse
Commencement of Leave of Absence	☐ EE	☐ Spouse
Return from Leave of Absence	☐ EE	☐ Spouse
Change in Worksite	☐ EE	☐ Spouse
Other	☐ EE	☐ Spouse

☐ Change in residence affecting eligibility. ☐ EE ☐ Spouse

☐ Change in spouse or dependent eligibility under and employer's plan.
☐ Loses / Gain eligibility (age, student, marital status)

☐ Other (Explain to right) ☐ EE ☐ Spouse

Changes In Cost & Coverage

(Note: changes in cost or coverage do not allow changes to the Health FSA)

☐ Significant cost increase in your or your dependent's coverage.

☐ Significant curtailment of your or your dependent's coverage.

☐ Addition or elimination of benefit package option under your or your dependent's employer's plan.

☐ Change in coverage or open enrollment of spouse or dependent under other employer's plan.

Explanation:
_____
_____
_____
_____
_____
_____

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

I HEREBY ELECT THE CHANGE(S) NOTED ON THE APPLICATION AND ELECTION FORM ATTACHED AND ATTEST THAT THE CHANGE IS MADE ON ACCOUNT OF AND CONFORMS WITH THE CHANGE IN STATUS OR CHANGE IN COST OR COVERAGE EVENT.

Employee Signature _____Date _____

Plan Administrator / Employer Signature _____ Date _____

Return this form to: Guardian FlexPlan, P.O.Box 26290, Lehigh Valley, PA 18002-6290
Phone: 1-866-359-4542 Fax: 610-807-8830 www.guardianflexplan.com FlexPlan@GLIC.com