

**CORONAVIRUS RELATED
SECTION 125 CAFETERIA PLAN ELECTION CHANGE FORM**



Name of Employer:	
Name of Employee:	
Social Security	Effective Date of Change:

Change my election(s) as follows:

(Forms that are not in good order will be returned to the Employer unprocessed.)

Premium Payment Plan:

Add the following coverages:

Drop the following coverages:

If you are revoking an existing election for employer-sponsored health coverage, by signing this election change form you are making the following attestation:

I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer-sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan.

Health Flexible Spending Account:	My current annual election is:	<input type="text"/>
	Amount of increase or decrease:	<input type="text"/>
	My new annual election is:	<input type="text"/>

Dependent Care Assistance Plan:	My current annual election is:	<input type="text"/>
	Amount of increase or decrease:	<input type="text"/>
	My new annual election is:	<input type="text"/>

NOTE: Your payroll deduction amount going forward will depend on the amount already contributed and paid out prior to your election change. Your new annual election will not be reduced below what has already been contributed to your account or what has already been claimed from your account.

You can not receive a refund of amounts already contributed. If no amount is entered no change will be recorded.

Employee Signature	Date
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To be completed by the Employer:

Employer Signature:

New per payroll deduction amounts for Health FSA and DCAP election changes will be provided to the employer after this form has been submitted in good order.

Return to Advantage Administrators:

By mail to:

PO Box 118, Waverly, IA 50677-0118

By fax to:

319-352-2610 or 319-352-4018

By email to:

customer@advantageadmin.com