VANTAGEPOINT
BENEFIT ADMINISTRATORS
A Division of J. Peat & Associates

PERSONAL BENEFIT ELECTION CHANGE Request Form

Employee _____   **SS#** _____

Employer: _____

Instructions

Step 1   Complete *Employee Statement of Qualifying Event* and attach applicable page to this request form.
Step 2   Determine what changes you can make by reviewing the *Change in Status Matrix*.
- Locate the qualifying change in status code "SC code" listed on the *Employee Statement of Qualifying Event* form
- Locate that same status code "SC code" on the *Matrix* listed in the left hand column
- Follow across to the column listing the benefit plan class you are interested in changing
- Where the row and column meet, there you will find authorized changes you can make.

Step 3   Complete this *Personal Benefit Election Change Request Form*
Step 4   Sign in the *Employee Signature* box and return to your benefits counselor within 30 days of the qualifying change in status event.

CHANGE IN BENEFIT ELECTION

PLAN CLASSES:
5.l (Core Health)	5.5 (Long-Term Disability)	5.11 (Group Dental)
5.2 (Non-Core Supplemental Health)	5.7 (Health FSA)	5.12 (Group Vision)
5.3 (Group Term Life)	5.8 (Dependent Care Assistance)	5.13 (AD&D)
5.4 (Short-Term Disability)	5.10 (Health Premium Reimbursement Account)	

☐ I WANT TO ELECT NEW BENEFIT(S)

Benefit	Option if Applicable (Employee Only, Family, etc.)	Plan Class (See above.)	Deduction Amount per Pay Period
			$
			$
			$

☐ I WANT TO TERMINATE BENEFIT(S)

Benefit	Option if Applicable (Employee Only, Family, etc.)	Plan Class (See above.)	Deduction Amount per Pay Period
			$
			$
			$

☐ I WANT TO REPLACE EXISTING BENEFIT WITH NEW BENEFIT

Benefit	Option if Applicable (Employee Only, Family, etc.)	Plan Class (See above.)	Deduction Amount per Pay Period
Replace:			$
With:			$

☐ I WANT TO CHANGE OPTIONS FOR ELECTED BENEFIT(S)

Benefit	Plan Class (See above.)	Replace Option	Deduction Amount per Pay Period	With Option	Deduction Amount per Pay Period
			$		$
			$		$
			$		$

☐ I WANT TO CHANGE RATES FOR A ELECTED BENEFIT

Benefit	Plan Class (See above.)	Option	From Deduction Amt per Pay Period	To Deduction Amt per Pay Period
			$	$

☐ I WANT TO ELECT BENEFIT OPTIONS FOR QUALIFYING FMLA

Instructions

If you selected SC 7.1.1 – **Beginning FMLA Leave** (#25) on the *Employee Statement of Qualifying Event* you now need to decide how you will pay your benefit premiums while you are on leave.

- List each applicable Benefit, Plan Class (found above) and check one payment option per benefit. Refer to the footnotes below for additional detail on each option

BENEFIT	PLAN CLASS	OPTIONS					
			Pay-As-You-Go		Catch Up		
		Prepay[1]	Pay Period[2]	COBRA[3]	Payroll Deduction[4]	Lump Sum[5]	Drop Coverage[6]

[1] Premiums may be pre-paid before going on FMLA leave (during same plan year) pursuant to your Cafeteria Plan.

[2] While on leave, you may elect to pay premiums to the Employer at the same time that they would be paid if by payroll deduction (with after-tax dollars)

[3] While on leave, you may elect to pay premiums to the Employer at the same time that they would be paid under COBRA which is typically once-a-month (with after-tax dollars)

[4] Upon return from leave, you may "catch up" on your premiums through payroll deduction with pre-tax dollars (if you return during same plan year). If you return after plan year has ended, you may "catch up" your premiums through payroll deductions with after-tax dollars.

[5] You may make a lump sum payment (with after-tax dollars)

[6] You may elect to drop coverage before going on leave.

SIGNATURES

Employee Signature Box

Attached is my *Employee Statement of Qualifying Event.* I hereby elect the benefit changes noted hereon and attest that these benefit change(s) is/are caused by and consistent with the qualifying change in status code "SC #_____". I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I also realize that the elections I have elected cannot be retroactive unless I am adding a new dependent and HIPAA special enrollment rights apply. I understand that the qualifying event and the resulting changes I have requested on this form must comply with my employer's plan, and the Plan Administrator has the sole discretion to make this determination. If my requested changes are denied, I understand that I will have 60 days to appeal the decision.

Employee Signature_____   Date_____

Employer Signature Box

Acceptance of Change Request

Process changes in benefit elections on Pay Period No. _____ Pay Date:_____

Authorized Signature:_____ Date:_____

PSP Change Entry Record   **VantagePoint Benefit Administrators**

Date Request Received:_____   Date Change Processed:_____

Processed by:_____   System Doc No.:_____

Signed:_____   Date:_____