HSA Contribution Status Change Form

Participant Name: ______________________________ SS # XXX-XX-__________

Participant Address: ______________________________ Badge # __________

This Change form applies to HSA Benefits <u>only</u>. These changes may be done prospectively for any reason.

STATUS CHANGE EFFECTIVE DATES (Check Applicable Boxes)

- ❑ **Change in Election**
  Effective ____________________ I hereby make a change to my existing election under my employer's Section 125 Plan (Health FSA, DCAP, Health Plans and HSA Components).
- ❑ **Revocation of Existing Election**
  Effective ____________________ I wish to REVOKE my existing election under my employer's Section 125 Plan (Health FSA, DCAP, Health Plans and HSA Components).
- ❑ **New Election**
  Effective ____________________ I hereby make a new election as specified on this Enrollment Form under my employer's Section 125 Plan (Health FSA, DCAP, Health Plans and HSA Components).

CHANGES IN DEDUCTIONS

HSA Medical/Dental/Vision Expenses
Prior Deduction: $
New Deduction: $
Prior Annual: $
New Annual: $
YTD contributions prior to new deduction: $
Starting pay period date:
No. of pay periods remaining:

Please read carefully: 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 the Plan, and the Administrator has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or has become entitled to Medicare/Medicaid, or (b) a judgment, decree, or order requires an individual other than myself to provide accident or health coverage for my child, I certify that such new, improved, or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person.

If my change in election is denied, I understand that I will have to appeal the decision within the timeframe specified in the Summary Plan Description for the Plan.

If approved I hereby elect the change(s) noted above or by new election on the attached Enrollment Form and attest that the change is made on account of and is consistent with the change in election event.

(Required)
PARTICIPANT SIGNATURE: ______________________________ **DATE SUBMITTED:** ______________

Accepted and agreed to:
EMPLOYER SIGNATURE: ______________________________ **DATE APPROVED:** ______________

Phone: (217) 902-5300
Fax: (217) 902-7800

Carle Health Human Resources
3310 Fields South Drive
Champaign, IL 61822