Change in Status Election Form

For Johnson Services Group, Inc.

Section 125 Premium Only Plan

Plan Year January 1, 2019 through December 31, 2019

Employee Name: ____

Employee Address: ____

Employee Number: ____

As a participant in the Premium Only Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in status:

- ___ Marriage.
- ___ Divorce, Legal Separation, or Annulment.
- ___ Birth, or adoption, or placement for adoption of a child.
- ___ Death of my spouse and/or dependent.
- ___ Termination or commencement of employment by my spouse or dependent.
- ___ A judgment, decree, or order (“order”) that affected eligibility for benefits.
- ___ I, my spouse, or dependent have had a change in employment status, including switching from part-time to full-time (or vice versa) or reduction or increase in hours a strike or lockout, that affected eligibility for benefits.
- ___ A change in the residence or worksite of myself, my spouse, or dependent that affected eligibility for benefits.
- ___ I, my spouse, or dependent have taken an unpaid leave of absence that affected eligibility for benefits.
- ___ My dependent satisfies or ceases to satisfy the requirements for coverage’s due to attainment of age, student status, or any similar circumstance.
- ___ A cost or coverage change in benefits that affected eligibility for me, my spouse, or dependent.
- ___ Eligibility for coverage during open enrollment or a Special Enrollment Period of a Marketplace Qualified Health Plan (QHP).
- ___ Moving from full-time status (at least 30 hours of service per week) to part-time status (less than 30 hours per week), even if the reduction in hours does not result in your ceasing to be eligible under the group health plan.
- ___ A change made under my spouse’s or dependent’s employer benefits plan if the election for a period of coverage for my Plan is different from the period of coverage (open enrollment) under the other cafeteria plan or qualified benefits plan.
- ___ I, my spouse or dependent who has been entitled to Medicaid or Medicare coverage lost eligibility. That individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

The Administrator may require you to provide evidence to document the event which requires the change of election.

By ______________________________ Date______________________________

Employee’s signature

Accepted and agreed to by the Employer’s Authorized Representative.

By ______________________________ Date______________________________

Administrator’s signature