

**BOSTON UNIVERSITY
FLEXIBLE BENEFIT PLAN MID YEAR CHANGES
CERTIFICATION STATEMENT**

Section 125 of the Internal Revenue Code prohibits changing your Flexible Benefit Plan elections during a year unless one of several specific events, defined as "Qualified Changes in Family Status" has occurred. In order to make a change in your Flexible Benefit Plan elections outside of the normal annual open enrollment period, you must meet one or more of the criteria listed below. In addition, the change you are requesting must be consistent with your qualified change in family status. **These changes are restricted to a thirty day deadline, therefore you have thirty days from the Date of the Qualifying Event to submit this form and appropriate adjustment forms for the affected plan(s). In addition, it is necessary for you to submit written proof of the Qualifying Event to this office. Please note that all changes become effective as of the date of the Qualifying Event.**

Section I: Qualified Changes in Family Status - Please check all that apply:

- Marriage, Civil Union or Divorce
 - Birth or Adoption of child
 - Start or loss of my spouse's employment
 - Myself or my spouse switching from part-time to full-time employment or from full-time to part-time employment
 - Death of a spouse or dependent
 - Myself or my spouse taking a leave of absence or sabbatical
 - My retirement or termination of employment
- [Note: If you revoke coverage because of retirement or termination you will not be permitted to re-enroll during the same plan year should you be rehired by the University.]

Section II: Date of the Qualifying Event: _____

Section III: Benefit Plan Change -The benefit I wish to change is:

- Health Benefits (**please indicate specific plan**)
 - Blue Cross Blue Shield PPO
 - Network Blue New England (HMO Blue)
 - Blue Cross Blue Shield Comprehensive Major Medical
 - Boston Medical Center Preferred
- Dental Benefits (**please indicate specific plan**)
 - BU Dental Health Center Plan
 - Dental Blue Freedom Plan
- Personal and Family Accident Insurance
- Dependent Care Reimbursement Account Program
- Health Care Reimbursement Account Program

Section IV: Please circle the change you wish to make:

Change from

Employee only, Employee plus child(ren),
Employee plus spouse, Family

to

Employee only, Employee plus child(ren)
Employee plus spouse, Family

Add new coverage

Employee only, Employee plus child(ren), Employee plus spouse, Family

Cancel coverage

Employee only, Employee plus child(ren), Employee plus spouse, Family

Section V: Additional Information-In addition to completing this form, you may need to submit additional documentation. Please contact the Benefits Office at **(617) 353-4487 or (617) 353-4473** to request any necessary forms.

Section VI: Signature - I request a mid year change in my Flexible Benefit Plan for the reason indicated above. I certify that the above information is correct, and that I will be held liable for any penalties resulting from false or misleading information.

Name (Please Print)

Employee ID Number

Signature

Date

Please return this form to: HUMAN RESOURCES, BENEFITS SECTION, 25 BUICK STREET, BOSTON, MA 02215

