flyte HUMAN CAPITAL MANAGEMENT

Employee Profile & Benefit Plan Change Form

Flyte HCM provides employers with the ability to make changes directly to employees' statuses, demographic information, and enrollment online through our Health Account Manager at https://flytehcm-employer.lh1ondemand.com. For manual processing, this form may be completed and forwarded to Flyte HCM by upload to https://portal.flytehcm.com or by email to clientservices@flytehcm.com. If you have any questions, please email clientservices@flytehcm.com or call 952.746.0000.

Member Information

First Name ______ MI ______ Last Name ______ Social Security Number ______ Company Name ______

Update Member Demographic Information *(members may update their own address and/or email through their online account)*

New Address ______

New Email ______

New Name ______

Pay Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly Effective Date ______

Termination of Employment *(COBRA Events must be submitted online at https://cobrapoint.benaissance.com if Flyte HCM administers)*

Last Day Worked ______ Last Day of Plan/Insurance Coverage *(if applicable)* ______

Date of Final Payroll Deductions *(if applicable)* ______ ***Please list final YTD total deductions below***

Dependent Care ______ Parking Expenses ______ Health Savings Account ______

Health FSA ______ Transit Expenses ______ Pretax Group Insurance Premiums ______

Pretax Individual Insurance Premium ______ Does amount deducted cover final monthly premium? ☐ Yes ☐ No

Changes in Status Affecting Plan Coverage and/or Payroll *(including Qualified Status Change Events)*

Please complete the section(s) below for each applicable benefit plan. If a Qualified Event is required to make a change, the change must be made within thirty (30) days of the Qualified Event. Please see ***Qualified Status Events Allowable Enrollment & Pretax Changes Table (Form C011)*** for a list of events and allowable changes.

Change Code/Event Name *(See Form C011)* ______ **Date Event Occurred** ______

Month Change Takes Effect *(if applicable)* ______ **Payroll Date Change Takes Effect** *(if applicable)* ______

Section 125 Flexible Benefits Plan (FSA, DEPCARE) *(Qualified Event Required)*

☐ Health FSA: New Election ______ New Deduction ______

☐ Dependent Care: New Election ______ New Deduction ______

Section 132 Parking & Transportation Plan

☐ Parking: New Election ______ New Deduction ______

☐ Transportation: New Election ______ New Deduction ______

Individual Insurance Premium *(Qualified Event Required if Pretax)*

☐ New Monthly Premium ______ New Deduction ______

☐ New Carrier or Billing Address ______

Pretax Group Insurance Premiums *(Qualified Event Required)*

☐ New Projected Total Plan Year Deductions ______

Health Savings Account (HSA)

☐ New Deduction ______

☐ New Coverage Level ☐ Single ☐ Family

☐ No Longer Eligible- Final Date of Eligibility ______

Health Reimbursement Arrangement (HRA, Section 105 Plan)

☐ Drop Spouse/Dependent from Coverage ______

☐ Drop Coverage - Final Date of Coverage ______

*Please attach a **Plan Participation Agreement** if adding a spouse or dependent.*

Minimum Essential Coverage (MEC)

☐ Drop Spouse/Dependent from Coverage ______

☐ Drop Coverage - Final Date of Coverage ______

*Please attach a **Plan Participation Agreement** if adding a spouse or dependent.*

______

Signature of Member *(not required on termination of employment)* Date

______

Signature of Payroll / HR Officer Name of Payroll / HR Officer *(printed)* Date