



Continuation of Coverage/No Plan changes Form

Plan Year

7/01/2020-6/30/2021

Name: _____ Effective Date: 07/01/2020

- I elect no changes to my benefits.** Please keep my current elections from the 7/1/19 to 6/30/20 previous plan year and apply to the 7/1/20 to 6/30/21 plan year comparable plans.

I understand by signing this form that I will not be able to make any plan changes until open enrollment next year for the 7/1/2021 to 6/30/2022 plan year. I will only be allowed to make changes due to a qualifying event such as a loss of coverage, birth of a child, change in life event such as marriage, etc. Documentation will be required to prove a qualifying event circumstance.

- I understand that I must complete an updated FSA or HSA deduction form to confirm my payroll deductions for the new plan year.

Signature

Date