Enclosed you will find the necessary forms which will allow you to make a change in your Fringe Benefits Management Company plan benefits. Please complete, sign and date this form and return it in the envelope provided along with the information highlighted. Please also indicate the benefits you wish to continue; whatever you do not check will be dropped automatically.

The requested change(s) will be effective the first of the month following receipt of all properly completed documentation. BEFORE YOU SEND IN YOUR PAPERWORK, MAKE SURE THAT YOU HAVE THIS FORM SIGNED AND DATED AND A COMPLETED FRINGE BENEFITS MANAGEMENT COMPANY ENROLLMENT FORM OR YOUR CHANGE CANNOT BE APPROVED.

1. A letter from your spouse or dependent's employer stating the date he/she was hired, effective date of insurance coverage, and dependent(s) covered (if applicable).
2. A letter from your spouse or dependent's employer stating the change in insurance coverage, effective date of that change and dependent(s) covered (if applicable).
3. A letter from your spouse or dependent's employer stating the he/she terminated or retired from employment, loss of coverage (medical, dental, vision, etc), and dependents that were covered.
4. A letter from your spouse or dependent's insurance company indicating the change insurance coverage, the effective date of that change and dependent(s) covered (if applicable)
5. A copy of your marriage certificate or dependent's marriage certificate.
6. A copy of your final divorce decree or a copy of the legal separation.
7. A copy of your spouse or dependent death certificate.
9. A letter from your personnel stating the date you or your spouse went on unpaid leave or returned from unpaid leave.
10. A copy of your spouse or dependent's Medicare/Medicaid card.
11. A letter from dependent's college indicating graduation.
12. A letter from your dependent's college stating, full, part-time or no enrollment.
13. A copy of ineligible dependent(s) birth certificate, driver's license or enlistment forms.
14. A copy of your dependent's adoption papers or legal custody papers.
15. A notarized statement indicating your non-dependent relative is now your dependent(s) daycare provider.
16. A statement from your dependent's daycare provider showing why the daycare can no longer be offered to your dependents(s).
17. Documentation showing exactly what the Change in Status is along with the date of that change.
18. A legal documentation showing the dissolvent or closing of family owned business.

If you should have any questions, please do not hesitate to call us at 1-800-342-8017.

Sincerely,

Customer Service
Fringe Benefits Management Company

__________________________________________, incurred a Change in Status as defined by the IRS rules and therefore wish to change my FBMC plan benefits as indicated on the enrollment form enclosed.

X ___________________________ X ___________________________
Signature Date
MOUNTAINEER FLEXIBLE BENEFITS
CHANGE IN STATUS FORM

Social Security #: Dept./Agency

Last Name (Please Print) First Name MI

Home Address Street City State Zip

Work Phone Home Phone E-mail

Please indicate the type of Change in Status incurred:

- Marriage
- Divorce
- Death (employee, spouse, or dependent)
- Birth of child
- Adoption of child
- Beginning or end of employment of spouse
- Ineligibility of dependent (due to age, marriage or loss of full-time student status)
- From full-time to part-time employment or vice versa (employee or spouse)
- Unpaid leave of absence (employee or spouse)
- Significant change in health coverage due to spouse's employment
- Beginning or end of employment of spouse
- Ineligibility of dependent (due to age, marriage or loss of full-time student status)
- From full-time to part-time employment or vice versa (employee or spouse)
- Military Leave

This is to certify that on ____________________ (date of event), I incurred the Change In Status checked above, and therefore wish to change my plan benefits as indicated below. I understand that the change requested must be consistent with the change status event and I have attached legal document of such change.† The change must be requested within 60 days of the change status event. DOCUMENTATION MUST BE INCLUDED TO PROCESS THIS CHANGE!

Signature ____________________________ Date __________________

†Examples of documentation include marriage, birth, or death certificate; divorce decrees; notices of legal separation; proof of change in spouse's employment; or adoption papers.

VISION CARE*

Choose coverage:
- Employee only
- Employee & Family
- No coverage

Choose plan:
- Exam Plus
- Full Service

DISABILITY INCOME PROTECTION

- Employee only
- No coverage

If you choose this benefit, you must include birthdate below.

- Month
- Day
- Year

MEDICAL EXPENSE ACCOUNT

- Terminate Account
- Start Account: I wish to contribute $ ______ per paycheck during the remainder of this plan year, to be taken from each of my remaining regular paychecks.
- Change Existing Account: I wish to change from $ ___________ per paycheck to $ ___________ per paycheck amount, to be taken from each of my remaining regular paychecks.

DEPENDENT CARE ACCOUNT

- Terminate Account
- Start Account: I wish to contribute $ _______ per paycheck during the remainder of this plan year, to be taken from each of my remaining regular paychecks.
- Change Existing Account: I wish to change from $ __________ per paycheck to $ __________ per paycheck amount, to be taken from each of my remaining regular paychecks.

I elect to receive the EZ REIMBURSE® Mastercard® Card. If you choose the card, you will be assessed a $20 per-plan-year annual fee.

DEPENDENT INFORMATION

If you selected any coverage level followed by this symbol **, you must complete dependent information below. Use an additional piece of paper if necessary.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SPouse</td>
<td>MONTH</td>
<td>DAY</td>
</tr>
</tbody>
</table>

Mail completed form to:
Fringe Benefits Management Company
P.O. Box 1878
Tallahassee, Florida 32303-1878
Customer Service 1-800-342-8017

FBMC/WV/CIS/0305