Flexible Spending Account (FSA) Change in Election Form

Complete this form and submit to HR/Benefits.

Name (Last, First, MI)	Social Security Number or ID Number	Daytime Phone

Street Address	City	State	ZIP Code

Date of Change Event	Last Pay Date *Employer use only*	Benefit Effective Date *Employer use only*

Type of Change Event—Please select appropriate event(s)

Change in Legal Marital Status

☐ Marriage ☐ Divorce or annulment
☐ Death of spouse ☐ Legal separation

Change in Number of Dependents

☐ Birth, adoption or placement for adoption
☐ Death of dependent child

Change in Dependent Eligibility

☐ Gain of eligibility due to age
☐ Loss of eligibility due to age

Change in Employment Affecting Eligibility

☐ Termination or commencement of employment
☐ Commencement of or return from unpaid leave

Other

☐ Judgment, decree, orders such as qualified medical child support order
☐ Entitlement to Medicare/Medicaid
☐ Commencement of or return from FMLA leave
☐ Other:

Change in Cost or Provider - Dependent Care FSA Only

*Cost changes are not allowed if the provider is a relative.

☐ Child reaches age 13
☐ Provider increased or decreased cost*
☐ Child stops or starts school changing need for daycare
☐ Change in daycare provider that resulted in a change in cost*
☐ Change in cost due to child reaching older age*
☐ Change in parent work schedule that reduces or increases daycare hours
☐ Daycare closed
☐ Other – Explain:

Changes to Health Care Flexible Spending Account (HCFSA) Contributions

☐ I wish to change my HCFSA contributions. My annual contribution amount will change from $ to $ (not to exceed the plan limit). My per-paycheck deductions will change accordingly.

☐ I wish to cancel my HCFSA contributions.

Explain reason for change:

Employer Use Only
# of Checks Remaining
_____ of _____
Per Check Amount
_____

Changes to my Dependent Care Flexible Spending Account (DCFSA) Contributions

☐ I wish to change my DCFSA contributions. My annual contribution amount will change from $ to $ (not to exceed $5,000 per calendar year). My per-paycheck deductions will change accordingly.

☐ I wish to cancel my DCFSA contributions.

Explain reason for change:

Employer Use Only
# of Checks Remaining
_____ of _____
Per Check Amount
_____

Employee Certification. I understand:

- I (or my eligible dependent) had a change event as defined in my employer's plan and IRC Section 125.
- The election change I wish to make must be consistent with and on account of the change event.
- I may be required to provide documentation of the change event.
- This request can only be considered if I submitted this form within the timeframe as stipulated in my employer's plan document.
- The effective date of the requested change, if approved, is the first pay period or the first of the month following the approval of the change.
- This change request, if approved, cancels any prior elections I have made and cannot be changed except as stated in my employer's plan document.
- The plan sponsor, my employer, has sole discretion to review my request for change and make a determination.

Employee Signature ✓_____ Date:

Employer Review

☐ Change approved. ☐ Change denied. Reason:

Employer Signature ✓ _____ Date: