



**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 <i>Employer use only</i>		Benefit Effective Date <i>Employer use only</i>	

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

<p><b>Change in Legal Marital Status</b></p> <p><input type="checkbox"/> Marriage      <input type="checkbox"/> Divorce or annulment</p> <p><input type="checkbox"/> Death of spouse    <input type="checkbox"/> Legal separation</p> <p><b>Change in Number of Dependents</b></p> <p><input type="checkbox"/> Birth, adoption or placement for adoption</p> <p><input type="checkbox"/> Death of dependent child</p> <p><b>Change in Dependent Eligibility</b></p> <p><input type="checkbox"/> Gain of eligibility due to age</p> <p><input type="checkbox"/> Loss of eligibility due to age</p> <p><b>Change in Employment Affecting Eligibility</b></p> <p><input type="checkbox"/> Termination or commencement of employment</p> <p><input type="checkbox"/> Commencement of or return from unpaid leave</p>	<p><b>Other</b></p> <p><input type="checkbox"/> Judgment, decree, orders such as qualified medical child support order</p> <p><input type="checkbox"/> Entitlement to Medicare/Medicaid</p> <p><input type="checkbox"/> Commencement of or return from FMLA leave</p> <p><input type="checkbox"/> Other:</p> <p><b>Change in Cost or Provider - Dependent Care FSA Only</b></p> <p><small>*Cost changes are not allowed if the provider is a relative.</small></p> <p><input type="checkbox"/> Child reaches age 13</p> <p><input type="checkbox"/> Provider increased or decreased cost*</p> <p><input type="checkbox"/> Child stops or starts school changing need for daycare</p> <p><input type="checkbox"/> Change in daycare provider that resulted in a change in cost*</p> <p><input type="checkbox"/> Change in cost due to child reaching older age*</p> <p><input type="checkbox"/> Change in parent work schedule that reduces or increases daycare hours</p> <p><input type="checkbox"/> Daycare closed</p> <p><input type="checkbox"/> Other – Explain:</p>
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<b>Changes to Health Care Flexible Spending Account (HCFSA) Contributions</b>		<p align="center" style="background-color: #4F81BD; color: white; margin: 0;"><b>Employer Use Only</b></p> <p align="center"># of Checks Remaining</p> <p align="center">_____ of _____</p> <p align="center">Per Check Amount</p> <p align="center">_____</p>
<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> I wish to cancel my HCFSA contributions.</p> <p>Explain reason for change: _____</p>		

<b>Changes to my Dependent Care Flexible Spending Account (DCFSA) Contributions</b>		<p align="center" style="background-color: #4F81BD; color: white; margin: 0;"><b>Employer Use Only</b></p> <p align="center"># of Checks Remaining</p> <p align="center">_____ of _____</p> <p align="center">Per Check Amount</p> <p align="center">_____</p>
<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> I wish to cancel my DCFSA contributions.</p> <p>Explain reason for change: _____</p>		

**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: \_\_\_\_\_