

# Flexible Spending Account (FSA)

## Benefit Election Change Form

(Must be completed within 30 days of the change in status and given to your employer to process and forward to Infinisource)

Employer name: \_\_\_\_\_

Employee name: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

### Benefit Election Changes

Please change the amount of my election **PER PAY PERIOD** as follows:

- |  |          |          |
|--|----------|----------|
| <input type="checkbox"/> Premium Conversion Option | FROM     | TO       |
| <input type="checkbox"/> Health FSA                | \$ _____ | \$ _____ |
| <input type="checkbox"/> Dependent Care FSA        | \$ _____ | \$ _____ |

Date of first payroll deduction in which change applies: \_\_\_\_/\_\_\_\_/\_\_\_\_

The changes requested above are **on account of and correspond with** the change in status checked below and occurring on the date shown. (Election changes must occur within 30 days of the event.)

Date of change in status event \_\_\_\_/\_\_\_\_/\_\_\_\_

<p><b>Change in legal marital status:</b></p> <input type="checkbox"/> Marriage <input type="checkbox"/> Death of spouse <input type="checkbox"/> Divorce <input type="checkbox"/> Legal separation <input type="checkbox"/> Annulment	<p><b>Change in number of tax dependents:</b></p> <input type="checkbox"/> Birth <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Adoption or placement for adoption  <p><b>Change in dependent's eligibility under an employer's plan:</b></p> <input type="checkbox"/> Lost eligibility due to age, marital status, or student status <input type="checkbox"/> Gained eligibility due to age, marital status, or student status	<p><b>Change in employment status of employee, spouse or dependents:</b> (Check one)</p> <input type="checkbox"/> Termination or commencement of employment <input type="checkbox"/> Strike/lock out <input type="checkbox"/> Commencement of unpaid leave of absence <input type="checkbox"/> Return from unpaid leave of absence <input type="checkbox"/> Part-time to full-time <input type="checkbox"/> Full-time to part-time <input type="checkbox"/> Change in work site (Premium Conversion Option only)	
<p><b>Premium Conversion Option and Health Care Flexible Spending Account only</b></p> <p><b>Entitlement to Medicaid or Medicare:</b></p> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <p><b>Judgment, decree or court order regarding</b> (Please attach documentation.):</p> <input type="checkbox"/> Divorce <input type="checkbox"/> Legal separation <input type="checkbox"/> Annulment <input type="checkbox"/> Change in legal custody (including a qualified medical child support order) <input type="checkbox"/> Foster child who is a tax dependent		<p><b>Premium Conversion Option only</b></p> <p><b>Change in residence:</b></p> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent  <input type="checkbox"/> Open enrollment of spouse's employer's plan <input type="checkbox"/> A change in the cost of coverage under the employer's group health plan(s) in which the employee participates <input type="checkbox"/> A change in coverage under the employer's group health plan(s) in which the employee participates <input type="checkbox"/> A change in coverage under the plan of the employer of the spouse or dependent <input type="checkbox"/> A change due to a HIPAA Special Enrollment Event (Please attach explanation).	
<p><b>Dependent Care Flexible Spending Account only</b></p> <input type="checkbox"/> Change of dependent care provider <input type="checkbox"/> Termination/reduction of dependent care election when child attains age 13			<input type="checkbox"/> Change of rate charged by <u>unrelated</u> dependent care provider

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked on this form. Original benefit elections will remain in effect for those accounts not affected by the above changes unless they are revoked because of a further change in status.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consistency Requirement:** All Participant election changes must be consistent with the change in status. For assistance on whether or not an election change would meet the consistency requirement, please contact Infinisource, Inc.

