Flexible Spending Account (FSA)
Benefit Election Change Form

(Must be completed within 30 days of the change in status)

Employer name: ____

Employee name: ______________________________ Soc. Sec. No.: ____________________

Benefit Election Changes

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

	FROM	TO
❑ Premium Conversion Option	$______________	$______________
❑ Health FSA	$______________	$______________
❑ 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 _____/_____/_____

Change in legal marital status:

- ❑ Marriage
- ❑ Death of spouse
- ❑ Divorce
- ❑ Legal separation
- ❑ Annulment

Change in number of tax dependents:

- ❑ Birth
- ❑ Death of Dependent
- ❑ Adoption or placement for adoption

Change in dependent's eligibility under an employer's plan:

- ❑ Lost eligibility due to age, marital status, or student status
- ❑ Gained eligibility due to age, marital status, or student status

Change in employment status of employee, spouse or dependents:

(Check one)

- ❑ Termination or commencement of employment
- ❑ Strike/lock out
- ❑ Commencement of unpaid leave of absence
- ❑ Return from unpaid leave of absence
- ❑ Part-time to full-time
- ❑ Full-time to part-time
- ❑ Change in work site (Premium Conversion Option only)

Premium Conversion Option and Health Care Flexible Spending Account only

Entitlement to Medicaid or Medicare:

- ❑ Employee
- ❑ Spouse
- ❑ Dependent

Judgment, decree or court order regarding (Please attach documentation.)**:**

- ❑ Divorce
- ❑ Legal separation
- ❑ Annulment
- ❑ Change in legal custody (including a qualified medical child support order)
- ❑ Foster child who is a tax dependent

Premium Conversion Option only

Change in residence:

- ❑ Employee
- ❑ Spouse
- ❑ Dependent

- ❑ Open enrollment of spouse's employer's plan
- ❑ A change in the cost of coverage under the employer's group health plan(s) in which the employee participates
- ❑ A change in coverage under the employer's group health plan(s) in which the employee participates
- ❑ A change in coverage under the plan of the employer of the spouse or dependent
- ❑ A change due to a HIPAA Special Enrollment Event (Please attach explanation).

Dependent Care Flexible Spending Account only

- ❑ Change of dependent care provider
- ❑ Termination/reduction of dependent care election when child attains age 13
- ❑ Change of rate charged by unrelated 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.

Fringe Benefits Administration • PO Box 5818 • Dayton, Ohio 45405
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