

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:

- Premium Conversion Option
- Health FSA
- Dependent Care FSA

FROM	TO
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

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>Change in legal marital status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Marriage <input type="checkbox"/> Death of spouse <input type="checkbox"/> Divorce <input type="checkbox"/> Legal separation <input type="checkbox"/> Annulment 	<p>Change in number of tax dependents:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Birth <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Adoption or placement for adoption <p>Change in dependent's eligibility under an employer's plan:</p> <ul style="list-style-type: none"> <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>Change in employment status of employee, spouse or dependents:</p> <p><i>(Check one)</i></p> <ul style="list-style-type: none"> <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>Premium Conversion Option and Health Care Flexible Spending Account only</p> <p>Entitlement to Medicaid or Medicare:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <p>Judgment, decree or court order regarding (Please attach documentation.):</p> <ul style="list-style-type: none"> <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>Premium Conversion Option only</p> <p>Change in residence:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <ul style="list-style-type: none"> <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>Dependent Care Flexible Spending Account only</p> <ul style="list-style-type: none"> <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 Infnisource, Inc.

