Employee FSA Change Form

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EMPLOYEE INFORMATION

Employer: ______________________________

Employee Last Name: ______________________ First Name: ____________________ Middle Initial: _____

Date of Birth: ______________________ 11-digit Member ID #:______________________

Home Phone: ______________________ Work Phone: ______________________

Email Address: ______________________________

NAME OR ADDRESS CHANGE

☐ Name Change (From):______________________ (To):______________________

☐ Address Change (From):______________________ (To):______________________

______________________ ______________________

______________________ ______________________

CHANGE IN STATUS (IF ALLOWED BY PLAN)

For a complete list of allowable changes, please contact your employer. In order to be considered a qualifying event, changes listed below must affect your eligibility.

☐ Marital Status (please describe): ______________________

☐ Number of Dependents (please describe): ______________________

☐ Employment Status (please describe): ______________________

☐ Spouse/Dependent's Eligibility under an employer's plan (please describe): ______________________

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☐ Cost or coverage (please describe): ______________________

(Please note: Changes in cost or coverage do not allow for changes to the Unreimbursed Medical Expenses Account)

☐ Change in Beneficiary: From: ______________________ To: ______________________

☐ Other (please describe): ______________________

AUTHORIZATION

Changes to unreimbursed or limited-purpose health-related expenses may only be made if allowed by the plan.

Changes must be made within 30 days of the qualifying event. Date of the qualifying event: ______________

Effective _____________ (the first day of the next payroll period), I hereby request that the new amount listed below be withheld from my paycheck due to the above qualifying event.

Unreimbursed Health-related Expenses (if allowed by plan): $ _______________

Dependent Care Expenses: $ _______________

Supplemental Premium Account: $ _______________

Employer Funded Unreimbursed Health-related Expenses $_______________

Limited Purpose Health-related Expenses: $_______________

Employee Signature:______________________________ Date:________________

Employer Signature:______________________________ Date:________________