



Employee Flexible Spending Account (FSA) Change Form

Instructions

The FSA Change Form allows you to change your election as allowed by your plan. Please review your Summary Plan Description prior to submitting your change to verify it follows your plan rules and the stated IRS requirements. In addition, changes must be consistent with the type of event, requested within 30 days of the qualifying event, and must be prospective.

**Your new election indicated on the reverse is only an estimate. The actual pay period election will depend on your plan's allowed changes, the election's approval by your employer, and the pay period in which your change is entered into the payroll system. Elections may not be decreased below what has already been reimbursed.

Please return the original to your employer and retain a copy for your records.

Need assistance determining your election? Use this worksheet to calculate your estimated election amount. Please note that it does not account for plans that prorate.

| | Health FSA | Dependent Care |
|---|-------------------|-----------------------|
| 1 Prior Annual Election Your most recent annual election | \$ _____ | \$ _____ |
| 2 New Annual Election Sum of the election for the entire plan year | \$ _____ | \$ _____ |
| 3 Amount Already Deducted this plan year | \$ _____ | \$ _____ |
| 4 New Annual Election Line 2 minus line 3 | \$ _____ | \$ _____ |
| 5 Remaining Number of Pay Dates during this plan year | _____ | _____ |
| 6 Maximum Pay Period Election Line 4 divided by line 5 | \$ _____ | \$ _____ |

Frequently Asked Questions

1. What does "consistent with the event" mean?

- a. A health FSA election change must be on account of, and correspond with, the change in status. It must affect *eligibility* for coverage under your plan. **Example:** A health FSA election may be increased for a newly eligible spouse/family or decreased if they/family become eligible under your health plan. You may not change your election if you gain a spouse, have no eligibility changes, and wish to cancel your election to save money.
- b. A Dependent Care Assistance Program (DCAP) election change must affect DCAP expenses and must correspond with the event. **Example:** A DCAP election may be canceled when your child turns 13 in the middle of a plan year because your child is no longer a qualifying individual for the purposes of DCAP rules.

2. What is prorating and how does it affect my election?

If your plan prorates, it means the maximum pay period deduction cannot exceed your plan maximum divided by the amount of pay periods in the year. **Example:** $\$2,600 \div 12 \text{ paydates} = \216.67 , so the most you may elect per pay date is \$216.67. If you join the plan partway through the year, and only have 6 pay dates in this plan year, the most you may elect is \$1,300 ($\216.67×6).

Resources

- **Summary Plan Description (SPD)** explains in detail the operation and rules that govern your plan. Refer to Section II, "Your plan at a Glance," to determine the specific features your employer offers and Section V, "Administrative Provisions—Election Changes," for additional information about election changes. Please contact your Human Resources Department to request a copy of your SPD.
- **FSA Handout** is an informal document that summarizes your plan and its specifications.



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Please print responses. * = required field

Employment

Employer* _____ PSA Member ID _____

Employee

Employee Last Name* _____ change First Name,* MI _____

Birth Date* _____ Social Security No. _____

Mailing Address* _____ change

City* _____ State* _____ ZIP* _____

Primary Phone _____ change Secondary Phone _____ change

Email _____ change

If provided, notifications may be sent via email.

Qualifying Event

Changes must be made within 30 days of the qualifying event, must be consistent with the event, and must be made prior to the your effective date. Changes will take effect on the first day of the next pay period following the qualifying event date.

Qualifying Event Date* _____ Next Pay Period Date* _____

Date New Deduction Will Be Taken _____

Health FSA: New Pay Period Election Amount** \$ _____ Health FSA: New Annual Election Amount** \$ _____

DCAP: New Pay Period Election Amount** \$ _____ DCAP: New Annual Election Amount** \$ _____

Select a change in status event.*

- Birth/Adoption of Child (may be retroactive) Date _____ Employee Regained Eligibility
- Change in Dependent Care Assistance Cost or Coverage Employee Rehired
- Change in Employment Status Self Spouse Ineligibility of Dependent (due to age, custody, or residence)
- Change in Legal Marital Status Marriage Divorce Legal Separation Judgement, Decree, or Court Order
- Death of Spouse Child Date _____ Other _____

Explanation of change* _____

Participant Authorization

Any person who, with an intent to knowingly defraud, files this application with materially falsified information or conceals material information may be subject to criminal and civil penalties and PacificSource Administrators may cancel such person's membership and refuse to pay their claims.

Employee Signature* _____ Date* _____

Employer Authorization* _____ Date* _____

Employer: Please audit the form, confirm the change is consistent with the event, and confirm your plan allows changes. Once approved, retain a copy for your records, and forward a copy to PacificSource Administrators for processing.