



# CHANGE FORM

## FLEXIBLE SPENDING ACCOUNTS

### WITH

## BENIVERSAL® MASTERCARD®

(PLEASE PRINT CLEARLY)



2320 Brighton-Henrietta Townline Rd  
Rochester, NY 14623  
Phone: (800) 473-9595  
Website: [www.BenefitResource.com](http://www.BenefitResource.com)

**EMPLOYER:** \_\_\_\_\_

**EFFECTIVE DATE OF CHANGE :**    /    /

**A. EMPLOYEE INFORMATION**

Member ID: \_\_\_\_\_

Employee Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Home Address: (Street) \_\_\_\_\_ (Apt #) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Birth Date:    /    /    Gender:     Male     Female

Hire Date:    /    /    Employee Status:     Full-Time     Part-Time

E-mail Address: \_\_\_\_\_

*(Note: Benefit Resource will only use your email address to communicate with you regarding your Plan.)*

**B. FLEXIBLE SPENDING ACCOUNTS** *Please enter any changes in FSA election(s) below.*

*(Refer to your Plan Highlights for election maximums)*

Medical Flexible Spending Account

Dependent Care Flexible Spending Account

**Per Pay Deduction**

\$ \_\_\_\_\_

\$ \_\_\_\_\_

**Plan Year Election**

\$ \_\_\_\_\_

\$ \_\_\_\_\_

**C. MID-YEAR CHANGE INFORMATION** *Please check applicable event.*

**NOTE:** • An election can only be changed if the change in status affects eligibility for that coverage.

• Any change in election must be consistent with the change in status and the change in eligibility.

- Participant's termination of employment.
- Change in employment status of spouse or dependent (including termination or commencement of employment).
- Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).
- Change in number of tax dependents (including birth, adoption, placement for adoption, death).
- Change in work schedule (reduction or increase in hours by employee, spouse or dependent, including a switch between full-time and part-time, a strike or lockout, and commencement of or return from an unpaid leave of absence).
- Change in residence or worksite (of employee, spouse, or dependent).
- Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).
- Change in dependent care cost or provider (for Dependent Care FSA elections only).
- Other \_\_\_\_\_

**D. EMPLOYEE CERTIFICATION**

By signing and submitting this change form, I authorize all changes as indicated above and understand that any change must be permissible under IRS regulations and as defined in the Plan. I understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I authorize any election amount(s) above to be deducted from payroll as indicated. I understand that unused amounts in any Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal MasterCard is associated with my Flexible Spending Account:

- I agree to use the Beniversal MasterCard only for eligible medical expenses under the Plan for me or a qualifying individual and to be bound by all provisions of the Beniversal *Cardholder Agreement* and *My Beniversal Use of Card Promises* sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the *Agreement*, I may lose Beniversal Card privileges and will reimburse the Plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper follow-up requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such follow-up documentation to Benefit Resource upon request.

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**E. PAYROLL DEDUCTION INFORMATION** *Employer must enter any changes below.*

• **Deduction cycle:**     weekly     bi-weekly     monthly     semi-monthly     other \_\_\_\_\_

• **First pay date of new FSA deduction(s):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

• **Number of pay dates on which new FSA deduction(s) will be taken during this Plan Year:** \_\_\_\_\_

• **Health Insurance Coverage Code:** \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ *(This six digit code can be obtained from your Group Insurance Information form.)*

*Note: If employee is not insured through employer sponsored insurance plans, enter NOMED.*

**Please return completed form to your employer.**

*The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.*