



# 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 Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Employee Name: (Last)	(First)	(MI)
Home Address: (Street)	(Apt #)	
(City)	(State)	(Zip Code)
Home Phone #:	E-mail Address:	
Hire Date:     /     /	Birth Date:     /     /	

**B. BENIVERSAL CARD**

*Employer use only*

Cancel my current Beniversal Card. I understand the card can no longer be used and should be destroyed by me.

X

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

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

	<u>Per Pay Deduction</u>	<u>Plan Year Election</u>
<input type="checkbox"/> Medical Flexible Spending Account	\$ _____	\$ _____
<input type="checkbox"/> Dependent Care Flexible Spending Account	\$ _____	\$ _____

**D. 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 \_\_\_\_\_

**E. 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 any unused amounts in either Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.
- If I use the Beniversal® MasterCard®, I agree to use the card 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 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 replacement card expenses to be deducted from my account balance.
- I understand that Federal law requires all 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 inquires about my Beniversal card. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.
- Since the IRS requires substantiation for certain purchases made with the Beniversal card, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such documentation to Benefit Resource upon request.

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

**F. 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 Carrier:** \_\_\_\_\_ **Health Insurance Plan Name:** \_\_\_\_\_

Note: If employee is not insured through employer Plan(s), enter *No Coverage*.

**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.*