

# CHANGE FORM

## FLEXIBLE SPENDING ACCOUNTS

(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 #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employee Status (please check one):    Full-Time    Part-Time

**B. 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 | \$ _____                 | \$ _____                  |

**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 the changes must be permissible under IRS regulations and as defined in the Plan. I also 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. Moreover, I authorize any amount(s) above to be deducted from payroll as indicated. I also understand that any unused amounts in either Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.
- I 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(s). I also understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

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

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