Flexible Spending Account Plan Election/Change Form

Please complete all fields on this application. Upon completion of this form please return it to your employer for processing.

PART 1: Employee Information

Employer Name:		Employer Location:	
Employee Name:		Employee Email Address:	
Employee Mailing Address:			
Employee's Full SSN:	Employer Employee ID:	Date of Birth:	Date of Hire:
Dependent 1: *(This information is required if you want to submit dependent care claims)*	Date of Birth:	Dependent 2:	Date of Birth:
Dependent 3:	Date of Birth:	Dependent 4:	Date of Birth:

PART 2: Benefit Election

☐ **New for Plan Year** ☐ **Change for remainder of Plan Year**

By electing coverage under the Company sponsored health plan(s), I designate premiums for eligible benefits to be paid on a pre-tax basis. These amounts, and if necessary, any Pay Conversion Contributions, will be adjusted if there is a change in premium amounts.

Reimbursement Accounts – Employee's Annual Election of Coverage
For a mid-year election change, indicate the new total Election of Coverage for the remainder of the Plan Year. If you do not wish to participate in one or more of the reimbursement accounts, write the word **"zero"** in the appropriate blank(s).

Health Care Flexible Spending Account: $ ______

Health Care Limited Purpose Flexible Spending Account: $ ______

Dependent Care Flexible Spending Account: $ ______

PART 3: Change in Family Status – Complete this section if the box "Change for remainder of Plan Year" is checked above

I understand I may change my benefit election only in limited circumstances in accordance with the Plan and, in any case, only upon a "Status Change" as defined by the Plan. By signing the employee authorization below, I hereby revoke my previous election, elect a new level of coverage and authorize my employer to reduce/increase my regular compensation to provide for Pay Conversion Contributions, if needed, for the remainder of the Plan Year in equal amounts per pay period. I am qualified to make this election change due to the following Status Change:

Date of status change: ______

☐ Dependent ceases to be eligible

☐ Change in employment status

☐ Change in number of dependents

☐ Adoption proceedings

☐ Change in marital status

PART 4: Employee Authorization

I hereby authorize my employer to make the pre-tax payroll deductions, which I have indicated in Part 3 above for Premium Conversion, Health Care Reimbursement, and/or Dependent Care Reimbursement and to reduce my regular compensation to provide for Pay Conversion Contributions as set forth in the Plan and as indicated in Part 2 above. I acknowledge that my Social Security Benefits may be slightly reduced as a result of my election. I understand that the amount I contribute for any Plan Year can be used only to reimburse me for expenses incurred in that Plan Year. Any monies remaining in my Flexible Spending Account(s) will be forfeited any applicable grace period or carryover allowed by the terms of the Plan and may not be paid to me in cash or used to provide future benefits. The Health Care and Dependent Care Flexible Spending Accounts are separate accounts, and any monies remaining in one cannot be used for the other. No further contributions can be made to the dependent care portion of the Plan after my termination date. However, I may continue to submit eligible dependent care claims for the entire Plan Year, or until my account balance has been depleted. **This election is irrevocable.** I understand that I cannot change or revoke my elections, unless I experience a "Status Change" as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with Status Change, as described in the Plan.

X ______ ______

Employee Signature **Date**

PART 5: Employer Information (to be completed by your employer)

Election or Change Effective Date:	First Deduction Date:
Payroll Frequency *(Required if employer has more than one frequency available):*	Number of Pay Cycles Remaining for the Year:

X ______ ______

Employer Signature **Date**

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