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FSA – CHANGE OF ELECTION FORM

Company Name

Plan Year_____

Name: _____ Soc. Sec. # _____

I understand that federal regulations prohibit me from changing the election I have made after the beginning of the Plan Year except for a change in family circumstances. I certify that I have incurred the following change in family status within the past 60 days:

- ☐ Marriage
- ☐ Divorce, legal separation or annulment
- ☐ Birth or adoption of a child or change in dependent status
- ☐ Change in dependent status
- ☐ Death of my spouse or child
- ☐ A significant change in medical benefits or premiums due to my or my spouse's employment status
- ☐ A judgement, decree or order requires me or another individual to cover my dependent child
- ☐ My spouse's unpaid leave of absence
- ☐ Termination or commencement of my spouse's employment
- ☐ Change of my or my spouse's employment status from full to part-time or vice versa

Please explain how this election change corresponds with the event:

_____

_____

Date event occurred _____.

Medical	**Dependent Care**
Old Annual Election Amount: _____	**Old Annual Election Amount: _____**
New Annual Election Amount: _____	**New Annual Election Amount: _____**

- ☐ Cancel all before tax deferrals for insurance
- ☐ Cancel the before tax deferrals for the insurance checked below
- ☐ Reinstate all before-tax deferrals for insurance
- ☐ Reinstate the before-tax deferrals for the insurance checked below
  - ☐ Medical Insurance (including all related coverages for medical and vision benefits)
  - ☐ Dental Insurance
  - ☐ Life Insurance
  - ☐ Disability Insurance

I hereby certify that the information furnished in this form is true and complete to the best of my knowledge. I understand that these new benefit elections will remain in effect through the last day of the Plan Year, unless I become eligible for another change in election.

Employee's signature: _____ Date: _____

Accepted and agreed to by: _____ Date: _____