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**Flexible Spending Account Change Form**

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| **Name (Last, First, MI)** | **Daytime Phone** | | **Division Code (ex: ABC1234)** | |
|  |  | |  | |
| Street Address | City/Town | | State | Zip Code |
|  |  | |  |  |
| Social Security Number | | Date of Qualifying Event | | |
|  | | \_ \_ / \_ \_ / 201\_ | | |

**TYPE OF QUALIFYING EVENTS** – Please select appropriate event(s)

* Termination/Leaving State Service
* Marriage
* Divorce
* Annulment
* Judgement, decree or court order
* Beginning LOA
* Ending LOA
* Became eligible for Medicare or Medicaid coverage
* Lost eligibility for Medicare or Medicaid coverage
* Birth, adoption or placement of a child
* Death of a spouse or dependent
* Dependent is no longer a qualified tax dependent
* Change in employee’s employment status
* Change in spouse’s employment status

**For DCAP only:**

* Child turned age 13
* Change in the cost of care
* Change of provider

**LEAVE OF ABSENCE (LOA)** including Family Medical Leave Act (FMLA) and Parental Leave

I’m beginning a LOA on \_ \_ / \_ \_ / 201\_ and wish to:

* Continue my HCSA participation while on LOA. I want to **PRE-PAY** my payroll contributions before my LOA.
* Continue my HCSA participation while on LOA. I want to **DIRECT PAY** my HCSA contributions by sending after-tax payments directly to ASIFlex.
* Discontinue my HCSA participation while on LOA. I understand I **cannot** request reimbursement from HCSA or use my Health Care FSA debit card for expenses incurred while on LOA.
* Discontinue my DCAP participation while on LOA. I understand I **cannot** request reimbursement from my DCAP account for expenses incurred while on LOA.

I’m ending a LOA on \_ \_ / \_ \_ / 201\_ and wish to:

* Reinstate my HCSA with the **same** **annual** amount. My per-paycheck contribution will **increase** accordingly.
* Reinstate my HCSA with the **same per-paycheck** amount. This will **reduce** the annual amount I originally elected.
* Reinstate my DCAP with the **same** **annual** amount. My per-paycheck contribution will **increase** accordingly.
* Reinstate my DCAP with the **same per-paycheck** amount. This will **reduce** the annual amount I originally elected.

**CHANGES TO HEALTH CARE SPENDING ACCOUNT (HCSA)**

I have a qualifying event and wish to:

* Change my HCSA contributions. My annual contribution amount will change from $\_\_\_\_\_\_\_ to $\_\_\_\_\_\_\_ (not to exceed $2,550). My per-paycheck deductions will change, increase/decrease, accordingly.
* Cancel my HCSA contributions. I understand I cannot request reimbursement from HCSA or use my Health Care FSA debit card for expenses incurred after this date.

**CHANGES TO DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)**

I have a qualifying event and wish to:

* Change my DCAP contributions. My annual contribution amount will change from $\_\_\_\_\_\_\_ to $\_\_\_\_\_\_\_ (not to exceed $5,000). My per-paycheck deductions will change, increase/decrease, accordingly.
* Cancel my DCAP contributions.

**By completing this form I understand:**

* I or an eligible dependent has had a qualifying change in status, as defined by the Internal Revenue Service, which allows me to change my pervious Health Care Spending Account (HCSA) and/or Dependent Care Assistance Program (DCAP) election.
* This form cancels any prior elections I have made under his plan, and cannot be changed except as stated in the GIC Participant Handbook – Fiscal 2017 Plan Year.

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| --- | --- | --- |
|  |  |  |
| Employee’s Signature |  | Date |
|  |  |  |
| Division HR Coordinator |  | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| The section below must be completed, in full, by agency Payroll Coordinator - Required | | | |
| Last Pay Date | \_ \_ / \_ \_ / 201\_ | Benefit Effective Date | \_ \_ / \_ \_ / 201\_ |
| HCSA: # of checks remaining \_\_\_\_ of \_\_\_\_ annually. Per-paycheck Amount $\_\_\_\_\_\_\_\_\_ | | | |
| DCAP: # of checks remaining \_\_\_\_ of \_\_\_\_ annually. Per-paycheck Amount $\_\_\_\_\_\_\_\_\_ | | | |