



Flexible Spending Account Change Form

State of Vermont

Name (Last, First, MI):		Social Security Number:	Daytime Phone:
Street Address:		City:	State: ZIP Code:
Date of Qualifying Event:	Last Pay Date <i>(Office use only)</i>	Benefit Effective Date <i>(Office use only)</i>	

Type of Qualifying Event Please select appropriate event(s)

- Marriage
- Divorce
- Annulment
- Began Family Medical Leave Act (FMLA) period (*Start Date* _____)
- Ended Family Medical Leave Act (FMLA) period (*End Date* _____)
- Became eligible for Medicare or Medicaid coverage

- Lost eligibility for Medicare or Medicaid coverage
- Judgment, decree or court order
- Death of spouse or dependent
- Dependent is no longer a qualified tax dependent
Explain: _____
- Change in employee's or dependent's employment status
Did spouse's employment status change? Yes No
- Birth, adoption or placement of adoption of a child

- For DCFSA only:**
- Child turned age 13
 - Change in the cost of care

Changes to Health Care Flexible Spending Account (HCFSA) Contributions

- I wish to change my Health Care Flexible Spending Account contributions. My annual contribution amount will change from \$_____ to \$_____ (not to exceed \$2,750). My per-paycheck deductions will change accordingly, starting with the second paycheck of the month after the latter of **(1)** the date of the qualifying event or **(2)** the date this form is received by ASIFlex.
- I wish to cancel my Health Care Flexible Spending Account contributions.

Office Use

of Checks Remaining _____ of _____
Per Check Amount _____

Changes to Flexible Spending Account (for FMLA only)

When beginning FMLA:

- I wish to continue my Health Care Flexible Spending Account participation while on FMLA. I must send after-tax payments to ASI.
- I wish to discontinue my Health Care and/or Dependent Care (circle one) Flexible Spending Account participation while on FMLA. I cannot request reimbursement from my Flexible Spending Account for expenses incurred while on FMLA.

When ending FMLA and returning to work:

- I wish to reinstate my Flexible Spending Account at the same **annual** amount. My per-paycheck deduction will increase accordingly.
- I wish to reinstate my Flexible Spending Account at the same **per-paycheck** amount. This will reduce the annual amount I originally elected.

Changes to my Dependent Care Flexible Spending Account (DCFSA)

- I wish to change my Dependent Care Flexible Spending Account contributions. My annual contribution amount will change from \$_____ to \$_____ (not to exceed \$5,000). My per-paycheck deductions will change accordingly, starting with the second paycheck of the month after the latter of **(1)** the date of the qualifying event or **(2)** the date this form is received by ASIFlex.
- I wish to cancel my Dependent Care Flexible Spending contributions.

Office Use

of Checks Remaining _____ of _____
Per Check Amount _____

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 previous Health Care Flexible Spending Account and/or Dependent Care Flexible Spending election.
- This form cancels any prior elections I have made under this plan, and cannot be changed except as stated in the *FSA Enrollment Guide*.

Employee Signature _____

Date _____

Please return this form to Human Resources within 60 days of the qualifying event.