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 *(Office use only)*	Benefit Effective Date *(Office use only)*

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 $10,500). 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.