Change of Election

This form is for your internal use only. Retain for your records.

A change of election must be (1) on account of and correspond to one of the qualifying events below and (2) made within 30 days of the qualifying event.

Participant Name _____ Participant ID # _____

Effective date of change_____First payroll affected by change _____

Type Of Change

I hereby request a change in my benefit election(s) as follows:

Benefit	Current Payroll Deduction Amount	New Payroll Deduction Amount	**Revised Annual Election***
Health Care FSA	$_____	$_____	$_____
Dependent Day Care	$ _____	$ _____	$_____

***Required to be entered.** The revised annual amount is determined by adding your year-to-date deductions taken at the old rate to your deductions to be taken for the remaining pay periods in the Plan Year.

Reason For Change (Qualifying Events)

Change in Legal Marital Status
Birth or Adoption of Child(ren)
Change in Employment Status
Leave of Absence
Entitlement to Medicare or Medicaid
Change of Employment Status or Insurance Eligibility of Spouse or Child

Participant's Signature _____

Employer's Signature _____

Participants: Submit this form to your employer and retain a copy for your records.

Employers: Retain this form for your records and forward form to info@flexmadeeasy.com