

**HEALTH CARE &
DEPENDENT CARE**

FLEXIBLE SPENDING ACCOUNT CHANGE FORM

Use this form to Increase, Decrease or Terminate your election following a status change event
Health Care Spending Account and Dependent Care Spending Account

Name (Please Print) Last		First	MI	State of Ohio User ID #	
Home Address Street		City	State		ZIP
Daytime Phone ()	Home Phone ()	Date of Hire	Date of Birth	Annual Salary	
E-mail Address					
CHANGE IN STATUS DATE: ____/____/____					

Types of Qualifying Event - Please select appropriate event(s)

<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Annulment <input type="checkbox"/> Began Family Medical Leave Act (FMLA) period (Start Date _____) <input type="checkbox"/> Ended Family Medical Leave Act (FMLA) period (End Date _____) <input type="checkbox"/> Became eligible for Medicare or Medicaid coverage	<input type="checkbox"/> Lost eligibility for Medicare or Medicaid coverage <input type="checkbox"/> Judgment decree or court order <input type="checkbox"/> Death of spouse or dependent <input type="checkbox"/> Dependent is no longer a qualified tax dependent Explain: _____ <input type="checkbox"/> Change in employee's or dependent's employment status Did spouse's employment status change? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Birth, adoption or placement of a child	For DCSA only: <input type="checkbox"/> Child turned age 13 <input type="checkbox"/> Change in the cost of care
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CHANGES TO HEALTH CARE SPENDING ACCOUNT (HCSA) CONTRIBUTIONS

I wish to change my Dependent Care Spending Account contributions. My annual contribution amount will change from \$ _____ to \$ _____ (not to exceed \$5,000). My per-paycheck deduction 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.

I wish to cancel my Dependent Care Spending Account contributions.

CHANGES TO DEPENDENT CARE SPENDING ACCOUNT (DCSA) CONTRIBUTIONS

I wish to change my Health Care Spending Account contributions. My annual contribution amount will change from \$ _____ to \$ _____ (not to exceed \$2,500). My per-paycheck deduction 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.

I wish to cancel my Health Care Spending Account contributions.

FMLA RELATED CHANGE IN STATUS

When Beginning FMLA:

I wish to continue my Flexible Spending Account and understand that my per paycheck deductions will continue. I realize that if I miss 3 deductions my account will close.

I wish to cancel my Flexible Spending Account and understand that I may reinstate with no break in coverage upon my return to work.

When returning from FMLA:

I wish to reinstate my Flexible Spending Account with no break in service and keep my original annual election amount. I realize my per paycheck deduction will increase accordingly.

I wish to reinstate my Flexible Spending Account with no break in service but want to change my election amount as stated above.

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 Spending Account and/or Dependent Care 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 SIGNED
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SUBMIT YOUR COMPLETED FORM TO P.O. BOX 1850, TALLAHASSEE, FL 32302-1850 OR FAX TO 850.514.5805.