WageWorks

HEALTH CARE & DEPENDENT CARE

State of Ohio

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
E-mail Address			

CHANGE IN STATUS DATE: _____ / _____ / _____ (Changes can be made between January 1 and September 30)

Types 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 a adoption of a child

For DCSA only:

- ☐ Child turned age 13
- ☐ Change in the cost of care

CHANGES TO HEALTH CARE SPENDING ACCOUNT (HCSA) 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.

CHANGES TO DEPENDENT CARE SPENDING ACCOUNT (DCSA) 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.

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

SUBMIT YOUR COMPLETED FORM TO P.O. BOX 14766, LEXINGTON KY 40512-4766 OR FAX TO 1-888-800-5217

Making Changes to Flexible Spending Accounts

The Flexible Spending Account Change Form should only be used if you are currently enrolled in a Health Care or Dependent Care Spending Account and have experienced an IRS Qualifying Change In Status (CIS).

The requested change can only be made if the completed form and appropriate supportive documentation is received by WageWorks within 31 days from the date of the qualifying event.

Below are examples of qualifying CIS events and acceptable forms of documentation:

Qualifying Event	Documentation
Marriage	official or temporary copy of marriage certificate
Divorce	copy of divorce decree that includes the judge's signature and date the divorce was finalized
Legal separation	copy of legal separation decree including the effective date
Death of Employee, Spouse, or Dependent	copy of death certificate
Adoption or Placement for Adoption of a Child*	copy of adoption papers or other court-issued forms that contain the judge's signature
Birth of a Child*	birth certificate, crib card, or hospital bill
Starting and/or Return from Unpaid Leave of Absence for Employee (i.e. Family Medical Leave Act, FMLA)	letter from the employer or personnel office stating the date the unpaid leave of absence began or the date of return to the payroll
Gain or loss of spouse's or dependent's eligibility for health insurance coverage due to a change in employment	letter from spouse's or dependent's employer stating the date of the employment change and the nature of the change in health insurance coverage
Gain or loss of dependent's eligibility status by attaining a specified age or due to a change in student or marital status	copy of birth certificate, documentation from dependent's college such as tuition bill or diploma, marriage certificate

* Coverage effective date is the date of the birth or the adoption

Consistency Rule: The proposed change in status must be consistent with the type of change experienced. For example, add a dependent and increase the election amount, or drop a dependent and decrease the election amount.