FLEXIBLE SPENDING ACCOUNT CHANGE FORM

Use this Form to Increase, Decrease or Terminate Your Election for the remainder of the Plan Year (changes will not be retroactive)

Name	Empl ID#
Email Address	Daytime Phone

The Year-End Budget Bill signed in December 2020, provided that employers could allow employees to make a change to their FSA election mid-year during the current plan year. The ability to make a change without a qualified status change event will only be available through June, 2021.

If you elect to cancel your Health FSA participation, you may be reimbursed only for expenses incurred while you were participating. To continue participating for the balance of the Plan Year and still reduce your election amount, you must continue to defer at least $5 per pay period.

HEALTH FLEXIBLE SPENDING ACCOUNT

Stop participation and deductions – I will only be reimbursed for claims incurred prior to the date my participation stops

Change my election to $___________________________ for the Plan Year (maximum of $2,750) - the amount already deferred from my pay will be subtracted from the amount elected above and the balance will be divided equally among the paychecks I receive during the remainder of the Plan Year

Change my election so the minimum $5 is deducted for the remaining pay periods in the year

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT

Stop deductions – I may be reimbursed for claims during the remaining plan year and subsequent grace period up to the amount I have deferred to date

Change my election to $___________________________ for the Plan Year (maximum of $5,000 per family) - the amount already deferred from my pay will be subtracted from the amount elected above and the balance will be divided equally among the paychecks I receive during the remainder of the Plan Year

I understand and authorize the following:

- I will forfeit any amounts left in my Health FSA and/or Dependent Day Care FSA after all eligible expenses are submitted for reimbursement. **(Eligible expenses must be incurred no later than September 15, 2021.)**
- Upon termination of my Health FSA participation, only eligible Health FSA expenses incurred prior to that date may be reimbursed. I understand I may be reimbursed for eligible Dependent Day Care Expenses incurred after my termination and prior to the end of the grace period up to the amount already deferred from my pay.
- I am responsible to keep and submit all receipts to the FSA Plan Administrator for unreimbursed health and/or dependent day care expenses. If I use my Health FSA debit card for Health FSA purchases, I will not need to submit my receipt unless asked by the administrator to verify that the expense was an eligible expense.
- I agree to use my Health FSA debit card only for eligible Health FSA expenses that are not reimbursable from another source.

I have read and understand the information on this form and I certify the information I have provided on all parts of this form is true and correct. I understand that knowingly providing a statement that contains any false, incomplete or misleading information may result in both adverse employment action, up to and including termination of employment, and adverse tax consequences, including penalties and interest. I hereby authorize the payroll deductions as required through the end of the Plan Year or my termination date, whichever occurs first.

Employee Signature: ____ **Date:** __________________________

UHRM Use Only	Entry Date:	Entered By:	QC By:	QC Date:

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