

Flexible Spending Account (FSA) Payroll Deduction Change Request

EMPLOYEE INFORMATION

Employee Full Name

Employee ID / Number

Department / Division

Email Address

REASON FOR CHANGE (QUALIFYING LIFE EVENT)

FSA elections are generally irrevocable for the plan year unless you experience a qualifying life event. Please select the event justifying this change and provide the event date.

☐ Marriage / Divorce ☐ Birth, adoption, or placement for adoption of a child ☐ Death of a spouse or dependent ☐

Change in employment status (spouse or self) ☐ Significant change in cost or coverage of care provider

Date of Qualifying Event

Requested Effective Date

FSA ELECTION & DEDUCTION CHANGE DETAILS

FSA Account Type	Current Per Pay Period Deduction	New Per Pay Period Deduction	New Total Annual Contribution
Health Care FSA			
Dependent Care FSA			

EMPLOYEE AUTHORIZATION

I hereby authorize my employer to adjust my pre-tax payroll deductions as indicated above. I understand that this authorization remains in effect for the remainder of the current plan year, unless I experience another qualifying status change. I certify that the information provided on this form is true and accurate.

Employee Signature

Date

HR / PAYROLL USE ONLY

Received By:		Date Received:	
Approved By:		Effective Pay Date:	
Processed In Payroll By:		Date Processed:	