



2020 FSA Status Change Form

Flexible Spending Accounts

Certificated

Classified

Last Name: _____

First Name: _____

ID #: _____

Address: _____

Phone: () _____

City: _____

State: _____

Zip: _____

INSTRUCTIONS: Please complete the information below and return form to the Employee Benefits Department within 30 days of the qualifying event specified. Not all of the qualifying events listed below are applicable to both the Health Care FSA and the Dependent Care FSA.

I have experienced the following family status change/qualifying life event and wish to revoke my existing election and make a new election for the remainder of the current plan year:

- Change in employee’s legal marital status (marriage, divorce, death of spouse, legal separation, and annulment)
- Change in the number of tax dependents (birth, adoption, placement for adoption, or death)
- Termination or commencement of employment by employee, spouse or dependent
- Change in work schedule (reduction or increase in hours) by employee, spouse, or dependent
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirement (e.g. attainment of age, student status)
- Change in residence of employee, spouse, or dependent affecting your eligibility for services
- Mid-Year Election Change due to COVID-19 under IRS Notice 2020-29.** An election cannot be changed to \$0 if there have been contributions made or claims reimbursed. Change forms received to “drop” future contributions will lower the annual election to the year-to-date amount taken by payroll deduction or total of claims reimbursed for the plan year whichever amount is greater.

<i>HEALTH CARE FSA</i>		<i>DEPENDENT CARE FSA</i>	
<i>New Annual Election</i>	<i>New Per Pay Amount</i>	<i>New Annual Election</i>	<i>New Per Pay Amount</i>
\$ _____	\$ _____	\$ _____	\$ _____

Authorization—Read Carefully

I understand that the choices I have indicated above must remain in effect for the remainder of the plan year. I certify that the election change that I have made is "on account of and consistent with" my family status change or qualifying life event which includes mid-year election changes due to COVID-19 under IRS Notice 2020-29. Change forms received to “drop” future contributions will lower the annual election to the year-to-date amount contributed by payroll deduction or amount reimbursed whichever amount is greater. I understand that contributions taken by payroll deduction will continue on a pro-rated basis through the end of the plan year if claims reimbursed exceed year-to-date contributions taken. **I understand that any unused balances in either the Health Care or Dependent Care account at the end of the plan year shall be forfeited.**

Signature of Employee

Date

FOR DISTRICT USE ONLY:		<i>Effective Date of Status Change:</i> _____	<i>Contributions YTD:</i> _____
<i>Reimbursements YTD :</i> _____	<i>No. of pay periods:</i> _____	<i>PS Entry Date :</i> _____	