Election Change Form
Flexible Spending Account

❑ ELECTION CHANGE ❑ NEW ELECTION (Newly Benefit Eligible Employees **Must** Complete the FSA Enrollment Form)

Name (Last, First MI)	
Agency/School District Name	**Employee ID Number + Last 4 SSN**
	-
Date of Qualifying Event	**Daytime Phone Number**

I certify that the following Qualifying Event has occurred:

❑ Marriage	**Health Care Only** ❑ Judgment, Decree or Court Order* **Copy of Order Required*	**Dependent Care Only** ❑ Provider Cost Change
❑ Divorce (finalized)/ Annulment		
❑ Death - Spouse or Dependent	**Health Care Only** ❑ Gain or loss of eligibility and coverage under Medicare/Medicaid	**Dependent Care Only** ❑ Provider Change
❑ Birth, Adoption or placement of adoption of a child	❑ Dependent satisfies or ceases to satisfy eligibility Explain_____	**Dependent Care Only** ❑ Child turns age 13
❑ Change in Employment Status of Employee, Spouse or Dependent ❑ Check here if Employment Status Change is for spouse Explain_____		**Dependent Care Only** ❑ FMLA Begin ❑ FMLA End Date_____

COMPLETED FORMS ARE DUE TO SBO WITHIN 30 DAYS OF THE QUALIFYING EVENT.

REQUESTS RECEIVED AFTER 30 DAYS WILL NOT BE APPROVED

I am requesting the following Election Change for the remaining Plan Year:

❑ **Health Care New Election for Plan Year*** (Plan year minimum of $50, maximum of $3,200) $_____	❑ **Dependent Care New Election for Plan Year*** (Plan year minimum of $50, maximum of $5,000) $_____	** Your election will be divided by the number of pay dates remaining in the plan year.*
❑ Stop Health Care FSA (*participation will end*)	❑ Stop Dependent Care FSA	

If the election change request is approved, the new election amount will be effective for expenses incurred the first of the month coincident with or following the event or the date the form is signed, whichever is later.

I hereby certify that the indicated event has occurred and agree that this requested change corresponds with requirements as mandated by Internal Revenue Code Regulations. I understand that this election will remain in effect throughout the remainder of the current Plan Year, unless I experience another Qualifying Event.

Employee Signature	Date

RETURN THIS FORM TO STATEWIDE BENEFITS OFFICE BY FAX, (302)739-8339.
PLEASE CONTACT STATEWIDE BENEFITS OFFICE, AT 1-800-489-8933 WITH QUESTIONS.

Qualifying Events
Flexible Spending Account

How do I request a change to my Flexible Spending Account (FSA) elections?

You may change your election or enroll during the plan year if you, your spouse, or a dependent experience an event listed below which results in a **gain or loss of eligibility** for coverage under the State of Delaware FSA or a similar plan maintained by your spouse or dependent's employer. **Your requested election change must correspond with that gain or loss of eligibility for coverage**.

If you experience a qualifying event, please complete the FSA Election Change Form. Completed forms are due to SBO **within 30 days** of the qualifying event. **REQUESTS RECEIVED AFTER 30 DAYS WILL NOT BE APPROVED.** If you have not experienced one of the qualifying events listed below, then you cannot make a change to your FSA until Open Enrollment.

Health Care FSA & Dependent Care FSA Plan Qualifying Events:

- Your legal marital status changes through marriage, divorce, death or annulment.
- Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. (If your child no longer qualifies for dependent care because he or she turned 13, then that is a loss of a dependent under the Dependent Care Flexible Spending Account Plan, but **not** under any of the other plans.)
- You, your spouse or any of your dependents have a change in employment status (termination, retirement, new employment, change from part time to full time or vice versa) that **affects eligibility for health insurance**.

Health Care FSA Plan Qualifying Events ONLY:

- You are served with a judgment, decree or court order, including a qualified medical child support order regarding coverage for a dependent.
- If you, your spouse or a dependent becomes **entitled to and covered under Medicare or Medicaid, you may drop or reduce coverage** under the Health Care Flexible Spending Account Plan.
- If you, your spouse or a dependent **loses eligibility and coverage under Medicare or Medicaid, you may add or increase coverage** under the Health Care Flexible Spending Account Plan.

Dependent Care FSA Plan Qualifying Events ONLY

- You change dependent care providers (including school or other free provider).
- You may make a corresponding change to your Dependent Care Flexible Spending Account if your dependent care provider who is not your relative changes your costs significantly.

When must claims be filed for the FY25 (July 1, 2024-June 30, 2025) Plan Year?

You will have until **October 15, 2025** to submit claims for reimbursement for eligible services received during the current Plan Year (July 1, 2024-June 30, 2025) and accompanying Grace Period (July 1, 2025-September 15, 2025). Any unused amounts remaining in my account as of October 15, 2025 will be forfeited.

For more information on Flexible Spending, visit the SBO website at https://dhr.delaware.gov/benefits/fsa/index.shtml.

Have Questions?

Please contact the Statewide Benefits Office Customer Service Team by phone at 1-800-489-8933 or by email at benefits@delaware.gov.