

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

COMPLETED FORMS ARE DUE TO SBO WITHIN 31 DAYS OF THE QUALIFYING EVENT.

REQUESTS RECEIVED AFTER 31 DAYS WILL NOT BE APPROVED

I am requesting the following Election Change for the remaining Plan Year:		
<input type="checkbox"/> Health Care New Election for Plan Year* (Plan year minimum of \$50, maximum of \$2,850) \$ _____	<input type="checkbox"/> Dependent Care New Election for Plan Year* (Plan year minimum of \$50, maximum of \$5,000) \$ _____	<i>* Your election will be <u>divided</u> by the number of pay dates remaining in the plan year.</i>
<input type="checkbox"/> Stop Health Care FSA (<i>participation will end</i>)	<input type="checkbox"/> 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 following the latter of: **1)** the date of the qualifying event, or **2)** the date this form is signed.

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



Your election under the Flexible Spending Plan is irrevocable for the Plan Year, unless you experience a qualifying event and **your requested election change corresponds with that gain or loss of coverage.**

When can I make a change to my Flexible Spending Account 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 Flexible Spending Account 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 have not experienced one of the qualifying events listed below, then you cannot make a change to your flexible spending until the next Annual Benefits 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.

How do I request the change to my Flexible Spending Account Elections?

If you have experienced one of the above qualifying events, please complete the Flexible Spending Account Election Change Form and return to the Statewide Benefits Office. It is the employee's responsibility to file the Election Change Form with the Statewide Benefits Office **within 31 days** of the qualifying event. **Requests received after 31 days will not be approved.**

For more information on Flexible Spending, visit the SBO website at de.gov/statewidebenefits.

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.