

Flexible Spending Account (FSA)

Election Change Request Form

Employee Name: _____

SSN: _____

Step 1: Check the box that indicates which event qualifies for a change in your FSA election.

The event must affect your eligibility for FSA coverage to be considered.

- Change in legal marital status** including marriage, death of spouse, divorce, legal separation and annulment.
- Change in the number of dependents** including birth, death, adoption, and placement for adoption.
- Change in employment status that affects eligibility for benefits of the employee, the employee's spouse, or the employee's dependent** including commencement of employment, termination of employment, commencement of or return from an unpaid leave of absence, full-time to part-time, part-time to full-time.
- Change in dependent's eligibility under an employer's plan** such as attainment of age, student status, or similar circumstances.
- Change in Dependent Care costs or provider.**
- Judgment, Decree or Order** affecting payment of benefits.
- COBRA Qualifying Event** with respect to the employee, the employee's spouse or employee's dependent and affecting coverage under the group health plan of the employee's employer.
- Entitlement to Medicare coverage.**

Step 2: Indicate how you wish to change your FSA election(s).

You may not decrease an election below what you have been reimbursed from or contributed to that account. The election change will be effective for expenses incurred during the remainder of the plan year. Your initial annual election will continue to apply to expenses incurred prior to the effective date of this election change.

Health FSA	<input type="checkbox"/> Increase my election to \$ _____.00	<input type="checkbox"/> Decrease my election to \$ _____.00	<input type="checkbox"/> Revoke my election YTD Deduction _____
Dependent Care FSA	<input type="checkbox"/> Increase my election to \$ _____.00	<input type="checkbox"/> Decrease my election to \$ _____.00	<input type="checkbox"/> Revoke my election YTD Deduction _____

Step 3: Sign below to indicate your approval of the following statement:

If approved, I hereby elect the changes indicated above to my FSA election(s) and attest that any changes requested are on account of and consistent with the change in election event. I understand I may be required to provide appropriate documentation and that this change in election request has the same effect as my initial annual election.

Employee Signature

Date

For Plan Administrator Use

Client: Loyola University New Orleans (LH1)	Client Code: L02571
Authorized Signature:	Name:
Election change effective date:	Payroll period effective date: