FLEXIBLE SPENDING ACCOUNT ENROLLMENT/ELECTION CHANGE FORM

FSA ELECTION CHANGES MUST BE FILED NO LATER THAN 31 DAYS AFTER A QUALIFYING EVENT.

Completed and signed forms and any required supporting documentation (see pg. 3) can be submitted to:

Division of Human Resources
888 N. Euclid Avenue, Suite 114
P.O. Box 210158
Tucson, Arizona 85721
Phone: (520) 621-3660 Fax: (520) 621-9098
E-mail: hrsolutions@email.arizona.edu

EMPLOYEE IDENTIFICATION INFORMATION (Print Clearly)

Last Name, First Name, M.I.			Salutation	EmplID **(Required)**
Work Phone	Cell Phone	Home Phone		Email address:
FOR HR USE ONLY	DATE RECEIVED:	EFFECTIVE DATE:		PROCESSED BY:

THE DATE OF EVENT:

I understand that I may change my Health Care Spending Account or Dependent Care Spending Account Election(s) if I experience a "qualified change in status" as mandated by Internal Revenue Code Regulations. I certify that the following "qualified change in status" has occurred.

Select one box below

- ☐ **Marriage**
- ☐ **Gain a Child** through birth, adoption
- ☐ **Loss of Dependent** through divorce, annulment, placement of adoption of a child or death (spouse/child)
- ☐ **Judgment, Decree or Court Order** (FSA Health Care only)
- ☐ **Dependent Eligibility Change**
  - ☐ Ceases to be eligible
  - ☐ Satisfies eligibility
- ☐ **Change in employment status of employee, spouse or dependent**
  - ☐ Check here if change is for spouse
- ☐ **Child reaches age 13** (FSA Dependent Care only)
- ☐ **Gain Eligibility and Coverage** under Medicare/Medicaid or AHCCCS (FSA Health Care only)
- ☐ **Loss of Eligibility and Coverage** under Medicare/Medicaid or AHCCCS (FSA Health Care only)
- ☐ **Cost Change** Dependent Care cost changes (cost change documentation required and provider may not be a relative)
- ☐ **Provider Change** (FSA Dependent Care only)
- ☐ **FML Status Change** – Please select from the boxes below
  - ☐ **FML Begins**
  - ☐ **FML Ends**

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FLEXIBLE SPENDING ACCOUNT- HEALTH CARE (Select an Action, Plan Type, and Coverage Level)

ACTION	PLAN	COVERAGE LEVEL (ANNUAL)
⎦ **Enroll** ⎦ **Decline** ⎦ **Increase** ⎦ **Decrease** ⎦ **No Change**	⎦ **FSA Health Care**	**Previous Annual Election $**_____ **New Annual Election* $**_____ ***Per pay period deductions are calculated based on the number of pay periods remaining in the calendar year.

FLEXIBLE SPENDING ACCOUNT- DEPENDENT CARE (Select an Action, Plan Type, and Coverage Level)

ACTION	PLAN	COVERAGE LEVEL (ANNUAL)
⎦ **Enroll** ⎦ **Decline** ⎦ **Increase** ⎦ **Decrease** ⎦ **No Change**	⎦ **FSA Dependent Care**	**Previous Annual Election $**_____ **New Annual Election* $**_____ ***Per pay period deductions are calculated based on the number of pay periods remaining in the calendar year.

DECLARATION FOR BENEFITS

- I authorize my employer to reduce my salary by applicable amounts I have elected in this form.
- I am aware that my contributions are ineligible as deductions for income tax purposes.
- I authorize the release of this information to the Flexible Spending Account vendor and my employer.

By my signature below, I authorize Human Resources to enter form information into the benefits enrollment system, affirm that it is my responsibility to review my paycheck and will immediately notify Human Resources of disparities.

Annual elections are required each year during the Benefits Open Enrollment period to retain coverage in the Flexible Spending Accounts.

Printed Name:_____ **Signature:** _____

Date:_____

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REQUIRED SUPPORTING DOCUMENTATION

All required documentation must be submitted in English (or translated to English).
Please see the payroll calendar for pay period start dates: http://www.fso.arizona.edu/Payroll/calendars.html.

Type of Event	Documentation Needed	Effective Date of Coverage
Marriage	Copy of Marriage Certificate.	**First day of the pay period following submission of completed forms and required documentation to HR**
Gain a Child	Birth- Copy of Birth Certificate (official or unofficial) or official hospital record. Adoption, Guardianship, Foster Care, Court Order- Copy of official signed and dated legal document.	
Loss of Dependent	Divorce, annulment- Copy of official signed and dated legal document. Death- Copy of Death Certificate.	
Child reaches Age 13	No supporting documentation needed if child is already listed as a dependent with a date of birth in UAccess.	
Judgment, Decree, Court Order	Copy of official signed and dated legal document.	
Loss of Eligibility and Coverage*	Official letter of loss of coverage from another FSA provider or employer stating effective date of loss of coverage.	
Gain of Eligibility and Coverage*	Official letter of gain of coverage from another FSA provider or employer stating effective date of new coverage.	
Cost Change	Letter or other official documentation from the dependent care provider (may not be a relative) showing the cost changes.	
Provider Change	Dependent Care Only- documentation must show date new provider services began.	
Family Medical Leave	FML paperwork must be filed with HR Department for date verifications.	

***If your dependent(s) have a different last name, proof of relationship (i.e. marriage/birth certificate) is required.**