

Flexible Spending Account (FSA) Change Form

Employee Information

Employee Name

Employee ID

Department

Email

Phone Number

Type of Change

☐

Enroll

☐

Increase Contribution

☐

Decrease Contribution

☐

Terminate Participation

Effective Date of Change

Select FSA Plan(s) and Amount

☐

Medical Expense FSA

Annual Election Amount

Per Pay Period Amount

☐

Dependent Care FSA

Annual Election Amount

Per Pay Period Amount

Reason for Change

☐

Marriage

☐

Divorce

☐

Birth/Adoption

☐

Change in Dependent Status

☐

Other

If Other, please specify:

Additional Comments

Employee Signature

Date