

Return this form to your HR dept. who will send to PayFlex via  
 1) Fax: 402-231-4283  
 2) Email: [flexmail@payflex.com](mailto:flexmail@payflex.com), or  
 3) Mail: PayFlex Eligibility  
 PO Box 981158  
 El Paso, TX 79998-1158

|   |       |          |   |                           |
|---|-------|----------|---|---------------------------|
| Company Name <i>(please print)</i>  |       |          | Plan Year                                 |                           |
| Employee Name <i>(Last, First, MI)</i>  |       |          | Member ID Number <i>(may be your SSN)</i> |                           |
| Employee Street Address <input type="checkbox"/> Check if this address is new within last year. |       |          |   |                           |
| City  | State | ZIP Code | Date of Birth (MM/DD/YYYY)                | Date of Hire (MM/DD/YYYY) |

When you have a qualifying status change, you may request a change in your election to revoke the existing plan election and make a new election for the remainder of the current plan year. The election change must comply with the IRS' "consistency rule" and be necessary since the event affects coverage eligibility of the employee, spouse or dependent.

**Change in Status: (Check all that apply)**

- Change in employee's legal marital status – including marriage, divorce, and death of a spouse, legal separation, and annulment.
- Change in number of dependents – including birth, death, adoption; and placement for adoption.
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements – an event that causes the dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, gain or loss of student status, marriage or similar circumstances.
- Change in cost or coverage for Dependent Care or Outside Premiums.
- Change in employment status of the employee, spouse or dependent that affects eligibility – including termination or commencement of employment; a strike or lockout; commencement of or return from unpaid leave of absence; change in worksite.
- Medicare/Medicaid Entitlement-employee may decrease or revoke election if they become entitled to Medicare/Medicaid; employee may commence or increase election if they lose eligibility for Medicare/Medicaid

**NOTE: Residence change (does not apply to reimbursement/spending accounts)**

**Election Effective Date:** \_\_\_\_\_ Enter the later of 1) the actual date of the event OR 2) the date this form is signed (this must be within 30 calendar days or as established by the Plan of the date of the event). (For a birth or adoption, enter the actual date of the event.)

**Pay Effective Date:** \_\_\_\_\_ Enter the first pay date for which this change will take place.

|                           | YTD Payroll Deductions Prior to Change | Future Contributions from change date through end of plan year | New Annual Election (should be combination of YTD and Future contributions) | # of Payrolls remaining | New Per Payroll Deduction Amount |
|---------------------------|--|--|---|-------------------------|----------------------------------|
| <b>Health Care FSA</b>    | \$ _____ . ____                        | \$ _____ . ____  | \$ _____ . ____   | \$ _____ . ____         | \$ _____ . ____                  |
| <b>Dependent Care FSA</b> | \$ _____ . ____                        | \$ _____ . ____  | \$ _____ . ____   | \$ _____ . ____         | \$ _____ . ____                  |

The section below should only be completed if an employee is going on a Leave of Absence due to FMLA or the plan is written that an unpaid leave does not result in a loss of eligibility. The following options are available and must be agreed upon by both Employee and Employer.

**As a result of my FMLA Leave of Absence (Paid or Unpaid), I agree to have my Flexible Benefits elections handled as follows:**

- Revoke my existing election-only available for unpaid FMLA.** I understand I will not be eligible for reimbursement of expenses incurred after the date of revocation.
- Prepay Option.** I wish to accelerate my deductions, prior to my leave of absence to ensure I can submit claims during my leave. I understand that this will increase my per pay period amount. For Dependent Care I understand that if I am not working during my leave, I will not be eligible for reimbursement for dependent care expenses.
- Pay-as-you-go Option.** I wish to pay my per pay period deduction on an after-tax basis during my leave of absence to ensure I can submit claims during my leave. I will pay this directly to my employer each pay date.
- Catch-Up Option.** I understand that the expenses I incur during my leave of absence status will not be reimbursed unless I return to work during the plan year and have deductions withheld to fulfill my annual election.

**As a result of my Unpaid Leave of Absence (non-FMLA) I agree to have my Flexible Benefits elections handled as follows:**

- Prepay Option.** I wish to accelerate my deductions, prior to my unpaid leave of absence to ensure I can submit claims during my leave. I understand that this will increase my per pay period amount. For Dependent Care I understand that if I am not working during my leave, I will not be eligible for reimbursement for dependent care expenses.
- Pay-as-you-go Option.** I wish to pay my per pay period deduction on an after-tax basis during my leave to ensure I can submit claims during my leave. I will pay this directly to my employer each pay date.
- Catch-Up Option.** I understand that the expenses I incur during my leave of absence status will not be reimbursed unless I return to work during the plan year and have deduction withheld to fulfill my annual election.

I, my spouse or an eligible dependent has had a qualifying change in status, as defined by the Internal Revenue Service and my benefit plan, which allows me to change my previous FSA election as indicated. This form changes my current election or indicates my payment method while on leave.

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Employer Signature** \_\_\_\_\_ **Date Approved** \_\_\_\_\_

**Contact Phone Number** (     ) \_\_\_\_\_