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Adair County Government

2017 Flexible Benefit Plan Change Form

Employee Name (Last, First, M.I.) :				Social Security Number
Address: City: State: Zip:				Phone:
Date of Birth:	☐Male ☐Female	☐Single ☐Married	Spouse Name:	Employment Date::

requirement is generally met if the event affects eligibility under this plan, or a spouse/dependent's FSA plan. The Plan Administrator has the final discretion to determine whether the eligibility requirement has been satisfied and may require additional documentation and/or explanation. This completed form must be returned within 30 days of the qualifying event.

Identify your qualifying event*:_____ **Date of qualifying event or Last Day Worked:**_____
*For details, please see "Status Change" in the Introduction & Purpose section of your FSA Master Plan Document.

Use this form if you are requesting FSA coverage to cease due to qualifying event (including employment termination), to change the current FSA coverage to another amount, or to begin a mid-year FSA election that you did not have before.

☐**Revoke / Terminate Existing FSA Election** I would like to request that my existing FSA election be ceased.
- ☐Medical Care FSA
- ☐Dependent Care FSA

☐**Change Current FSA Election** I would like to request a CHANGE be made to my existing FSA election
- ☐Medical Care FSA $_____
- ☐Dependent Care FSA $_____

☐**Begin a Mid-Year FSA Election** I would like to request a MID-YEAR FSA ELECTION be started on my behalf
- ☐Medical Care FSA $_____
- ☐Dependent Care FSA $_____

Medical Care Reimbursement Worksheet. I request the following amounts to be deducted pretax:

Medical Care Reimbursement:	_____	-	_____	=	_____	÷	_____	=	_____
Dependent Care Reimbursement:	_____	-	_____	=	_____	÷	_____	=	_____
	New Election		YTD Contribution		Remaining Deductions		# of Pay Periods Remaining		*Paycheck Deduction

*New Paycheck deduction begins:_____ Effective Date (if new benefit election):_____

Terminations: Date of Last Check: _____ # of Updates Remaining:_____ Last Contribution Withholding:_____

I understand my FSA coverage revocation or new election request must be filed within 30 days of the qualifying event and that the change must be directly because of and conform with that event. I may be required to provide the Plan Administrator with appropriate documentation regarding the qualifying event indicated and that I will receive notification of denial regarding my election change request after this form is processed. I also understand that the determination of the Plan Administrator will be final. I request and authorize these payroll deduction changes for the current Section 125 Plan Year.

Signature:_____ Date:_____

Employer:_____ Date:_____