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Return this form to the Benefits Unit of the Personnel Department.

Flexible Spending Account (FSA) Election Change Form

Employer Name: County of Santa Cruz			**Plan Year**:
Employee Name (Last, First, MI):			**Member ID (Employee Payroll Number)**:
Employee Mailing Address: ☐ **Check if this address is new within the last year.**			
City:	**State**:	**Zip Code**:	**Date of Birth (MM/DD/YYYY)**:

Under the Code of Federal Regulations (CFR) 1.125.4 – *Permitted Election Changes:* if a qualifying event exists, the Internal Revenue Service (IRS) allows employees to revoke or make election changes to their Flexible Spending Account plan outside of an Open Enrollment period.

Qualifying Event: (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 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.
- ☐ Change in place of residence.
- ☐ Other (Please specify the Permitted Election Change):_____

Election Effective Date:_____ *Enter the later of 1) the actual date of the event OR 2) the date the form is signed (this must be within 30 calendar days from the date of the qualifying event, or the date of a birth or adoption).*

Pay Effective Date: _____ *Enter the first date of the pay period 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 pay periods remaining	New Per Pay Period Deduction Amount

NOTE: The election changes are subject to the approval of the Health Benefit Officer.

I or my eligible dependent (s) have a qualifying event, as defined by the IRS, which allows me to change the FSA election as indicated above.

✍ **Employee Signature:**_____ **Date:**_____ **Contact Number:**_____

✍ **Health Benefits Officer:**_____ **Date Approved:**_____

Revised: May 2020