2021 Seattle Housing Authority Flexible Spending Account
CHANGE FORM ONLY

Employee ____________ ____________ ____________ **2021**

First Name | Last Name | Employee Number | Plan Year

EMPLOYEE ACTION – Type of Event/Contribution Election

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter a new election in the event of certain changes in status events.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status event and that the change must be acceptable under the Regulations issued by the Department of Treasury and/or within 30 days (or 60 days for a new child) of that change.

The effective date for the change actions is the first of the month following the change, subject to payroll deadlines. My monthly contribution will appear on my earnings statement.

Life Status Change - Changes permissible due to these events must be on account of and correspond with the event. Check the reason you are completing the form on Page Two and enter the date of the event and your contribution amount.

Type of Action ☐ Enroll ☐ Change Contribution (increase or decrease) ☐ De-enroll

	Date of event	Current Contribution	New Contribution
Health Care	(Mo/Day/Year)	$ Yearly amount	Yearly amount
Dependent Care	(Mo/Day/Year)	$ Yearly amount	Yearly amount

The monthly contribution will be calculated by dividing the annual amount by the number of remaining pay periods in the year.

For Health FSA only – Approved Family Medical Leave (FML)

During my Family Medical Leave without pay:

☐ Continue my coverage. I will self-pay my monthly premium with after-tax dollars during my Leave

☐ Cancel my coverage. Upon my return, my monthly contribution will be the same as before the leave, except the annual amount will be reduced by the number of contributions missed while on leave.

☐ Cancel my coverage. Upon my return, my annual contribution will be the same as before the leave, but I will make-up contributions to remain at that annual election.

Signature

My signature indicates I have read and agree to the “Terms and Conditions” on this form. I certify under penalty of lying under oath that all of the above information is true to best of my knowledge and, if applicable, that I have experienced the event and/or cost change noted above.

Signature of Employee *(required, regardless of election)* ____________ Date ____________

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Flexible Spending Account Change Form

Health FSA Life Status Change Events

CHANGE IN MARITAL STATUS
☐ You marry
☐ You marry and either – ▪ you and/or your dependent become eligible under and enroll in your new spouse's own employer's health plan, or ▪ your spouse is enrolled in his or her own employer's health FSA
☐ You lose your legal spouse through death, divorce, legal separation or annulment
☐ You lose your legal spouse through death, divorce, legal separation or annulment and you and/or your dependent lose coverage under your spouse's employer's health plan or health care FSA
GAIN OR LOSS OF A DEPENDENT
☐ You gain an eligible dependent (for example, through birth, adoption or your eligible child moves in with you)
☐ You lose an eligible dependent or a dependent loses eligibility (for example, through death, or when an individual is no longer financially supported by you)
CHANGE IN EMPLOYMENT STATUS
☐ You, your spouse or dependent gains eligibility for and enrolls in own employer's health FSA, or enrolls self and you in own employer's health plan because you/he/she - ▪ starts employment or ▪ has an employment status change
☐ You, your spouse or dependent loses eligibility for own employer's health FSA or health care because you/he/she - ▪ ends employment, or ▪ has an employment status change occurred?

Services incurred prior to the change in status event can only be reimbursed to the maximum benefit in place on the date that the service was incurred. It is not available from the new election amount.

Dependant FSA Life Status Change Events

CHANGE IN MARITAL STATUS
☐ You marry and gain a dependent
☐ You marry and your spouse is either not employed, or is enrolled in his or her own employer's dependent care FSA
☐ You lose your spouse through death, divorce, legal separation or annulment and your spouse was enrolled in his or her own employer's dependent care FSA
GAIN OR LOSS OF DEPENDENT
☐ You gain an eligible dependent (for example, through birth, adoption, or your spouse becomes incapable of self-care)
☐ You lose an eligible dependent (for example, through death, a child reaches age 25 or child is no longer a tax dependent)
CHANGE IN EMPLOYMENT STATUS
☐ Your spouse gains eligibility for and enrolls in own employer's dependent care FSA because he/she starts employment, or has an employment status change
☐ Your spouse loses eligibility in own employer's dependent care FSA because eh/she ends employment, or has an employment status change
COST CHANGE (DOES NOT APPLY IF PROVIDER IS YOUR RELATIVE BY BLOOD OR MARRIAGE)
☐ Your dependent care provider increase the cost of service
☐ There is a decrease in provider's cost
CHANGE IN PROVIDER OR COVERAGE
☐ You change dependent care providers
☐ Your spouse starts employment
☐ Your spouse ends employment
☐ There is a reduction in hours or cessation of dependent care (for example, a child starts attending school)
☐ You change (in whole or in part) from paid care to no care or free care (for example, free care by a neighbor, relative or for state-paid care
☐ You change (in whole or in part) from free/no care to paid care
☐ You or your spouse changes work schedules, which creates changes or eliminates need for dependent care
☐ Your spouse who is not employed or looking for employment becomes a full-time student, or becomes incapable of self care
☐ Your spouse who is not employed or looking for employment is no longer a full-time student, or is no longer incapable of self care

Please Forward this Form to the Benefits Administrator

EMPLOYER USE ONLY COMPLETE BEFORE SENDING TO Navia Benefit Solutions

TERMINATIONS & LEAVES

Date of Termination/Leave ______________ Last Pay Period Contribution Date __________________

Date of Return to Work _________________ First Contribution Date upon Return _________________

Employer Authorized Signature

Total YTD Contribution