



Flexible Spending Change of Election



A change of election must be (1) on account of and correspond to one of the qualifying events below and (2) made within 30 days of the qualifying event.

Participant Name _____ Participant ID # _____

Effective date of change _____ First payroll affected by change _____

TYPE OF CHANGE

I hereby request a change in my benefit election(s) as follows:

	Current Payroll Deduction Amount	New Payroll Deduction Amount	Revised Annual Election Amount*
Medical Flexible Spending Account (FSA)	\$ _____	\$ _____	\$ _____
Dependent Care (DCAP)	\$ _____	\$ _____	\$ _____

***Required to be entered.** The revised annual amount is determined by adding your year-to-date deductions taken at the old rate to your deductions to be taken for the remaining pay periods in the Plan Year.

REASON FOR CHANGE (Qualifying Event(s))

- | | | |
|--|---|---|
| <input type="checkbox"/> Change in Legal Marital Status | <input type="checkbox"/> Change in the Cost of Coverage* | <input type="checkbox"/> Change in Coverage of Spouse or Dependent Under Other Employer's Plan* |
| <input type="checkbox"/> Change in Number of Dependents | <input type="checkbox"/> HIPAA Special Enrollment Rights* | <input type="checkbox"/> Loss of Group Health Coverage Sponsored by Governmental or Educational Institutions* |
| <input type="checkbox"/> Change in Employment Status | <input type="checkbox"/> Judgment, Decree, or Order | <input type="checkbox"/> Exchange Event: Reduction in Hours (less than 30)* |
| <input type="checkbox"/> Dependent Satisfies or Ceases to Satisfy Eligibility Requirements | <input type="checkbox"/> Significant Curtailment of Coverage* | <input type="checkbox"/> Exchange Event: Exchange Enrollment during Exchange Open or Special Enrollment Period* |
| <input type="checkbox"/> Change in Residence* | <input type="checkbox"/> Addition/Elimination of Benefit Package* | |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> Entitlement to Medicare or Medicaid | |
| <input type="checkbox"/> FMLA | | |

* The Medical Flexible Spending Account (FSA) can not be changed due to one of these nine events.

Participant (Employee) Signature _____ Date _____

Client (Employer) Signature _____ Date _____

Participants: Submit this form to City of Madison Human Resources and retain a copy for your records. Contact Human Resources at benefits@cityofmadison.com or (608) 266-4615 with questions about this form.

Employers: Retain this form for your records and enter the change(s) above in the participant's account at www.connectyourcare.com prior to the first affected payroll.

CYC • 307 International Circle Suite 200 • Hunt Valley, MD 21030 • 877-292-4040 • Fax: 443-681-4601 • www.connectyourcare.com

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