THE UNIVERSITY OF ARIZONA
Human Resources

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT/ELECTION CHANGE FORM

**FSA ELECTION CHANGES MUST BE FILED NO LATER THAN 31 DAYS AFTER A QUALIFYING EVENT.**

Completed and signed forms and any required supporting documentation (see p. 3) can be submitted to:


**Division of Human Resources**
**888 N. Euclid Ave., Ste. 217**
**P.O. Box 210158**
**Tucson, AZ 85721**
**Phone: 520-621-3660**

**Email: hrsolutions@arizona.edu**

Or use **secure document upload**


**EMPLOYEE IDENTIFICATION INFORMATION**

| Last Name, First Name, M.I. | | | EmplID **(Required)** |
|---|---|---|---|
| Contact Phone | | Email address: | |
| **FOR HR USE ONLY** | DATE RECEIVED: | EFFECTIVE DATE: | PROCESSED BY: |

**DATE OF EVENT:**

I understand that I may change my Health-Care Spending Account or Dependent-Care Spending Account Election(s) if I experience a "qualified change in status" as defined in Internal Revenue Code Regulations. I certify that the following "qualified change in status" has occurred.

*Select one box below*

- ◯ **Marriage**
- ◯ **Gaining a Child** through birth, adoption, guardianship
- ◯ **Loss of Dependent** through divorce, annulment, placement of child for adoption, or death (spouse/child)
- ◯ **Judgment, Decree, or Court Order** (Health-Care FSA only)
- ◯ **Dependent Eligibility Change**
  - ◯ No longer eligible
  - ◯ Recently became eligible
- ◯ **Change in employment status of employee, spouse or dependent**
  - ☐ Check here if change is for spouse
- ◯ **Child reaches age 13** (Dependent-Care FSA only)
- ◯ **Gaining Eligibility and Coverage** under Medicare/Medicaid or AHCCCS (Health-Care FSA only)
- ◯ **Loss of Eligibility and Coverage** under Medicare/Medicaid or AHCCCS (Health-Care FSA only)
- ◯ **Cost Change** Dependent care cost changes (cost change documentation required; provider may not be a relative)
- ◯ **Provider Change** (Dependent-Care FSA only)
- ◯ **FML Status Change** – Please select from the boxes below
  - ◯ **FML Begins**
  - ◯ **FML Ends**

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT/ELECTION CHANGE FORM

**HEALTH-CARE FLEXIBLE SPENDING ACCOUNT**(Select an Action, Plan Type, and Coverage Level)

| ACTION | PLAN TYPE | COVERAGE LEVEL (ANNUAL) |
|---|---|---|
| ◯ **Enroll**<br>◯ **Decline**<br>◯ **Increase**<br>◯ **Decrease**<br>◯ **No Change** | ☐ **Health-Care FSA** | **Previous Annual Election $**_____<br>**New Annual Election* $**_____<br>*****Per-pay-period deductions are calculated based on the number of pay periods remaining in the calendar year. |

**DEPENDENT-CARE FLEXIBLE SPENDING ACCOUNT** (Select an Action, Plan Type, and Coverage Level)

| ACTION | PLAN TYPE | COVERAGE LEVEL (ANNUAL) |
|---|---|---|
| ◯ **Enroll**<br>◯ **Decline**<br>◯ **Increase**<br>◯ **Decrease**<br>◯ **No Change** | ☐ **FSA Dependent Care** | **Previous Annual Election $**_____<br>**New Annual Election* $**_____<br>*****Per-pay-period deductions are calculated based on the number of pay periods remaining in the calendar year. |

**DECLARATION FOR BENEFITS**

- I authorize my employer to reduce my salary by applicable amounts I have elected in this form.
- I am aware that my contributions are ineligible as deductions for income tax purposes.
- I authorize the release of this information to the Flexible Spending Account vendor and my employer.

By my signature below, I authorize Human Resources to enter form information into the benefits enrollment system, affirm that it is my responsibility to review my paycheck and to immediately notify Human Resources of discrepancies.

**Annual elections are required each year during the Benefits Open Enrollment period to retain coverage in the Flexible Spending Accounts.**

**Printed Name:**_____ **Signature:** _____

**Date:**_____

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT/ELECTION CHANGE FORM

## REQUIRED SUPPORTING DOCUMENTATION

**All required documentation must be submitted in English (or translated to English).**
Please see the payroll calendar for pay period start dates: http://www.fso.arizona.edu/Payroll/calendars.html.

| Type of Event | Documentation Needed | Effective Date of Coverage |
|---|---|---|
| **Marriage** | Copy of Marriage Certificate. | **First day of the pay period following submission of completed forms and required documentation to HR** |
| **Gain a Child** | Birth- Copy of Birth Certificate (official or unofficial) or official hospital record.<br><br>Adoption, Guardianship, Foster Care, Court Order- Copy of official signed and dated legal document. | |
| **Loss of Dependent** | Divorce, annulment- Copy of official signed and dated legal document.<br><br>Death- Copy of Death Certificate. | |
| **Child reaches Age 13** | No supporting documentation needed if child is already listed as a dependent with a date of birth in UAccess. | |
| **Judgment, Decree, Court Order** | Copy of official signed and dated legal document. | |
| **Loss of Eligibility and Coverage*** | Official letter of loss of coverage from another FSA provider or employer stating effective date of loss of coverage. | |
| **Gain of Eligibility and Coverage*** | Official letter of gain of coverage from another FSA provider or employer stating effective date of new coverage. | |
| **Cost Change** | Letter or other official documentation from the dependent care provider (may not be a relative) showing the cost changes. | |
| **Provider Change** | Dependent Care Only- documentation must show date new provider services began. | |
| **Family Medical Leave** | FML paperwork must be filed with HR Department for date verifications. | |

***If your dependent(s) have a different last name, proof of relationship (i.e. marriage/birth certificate) is required.**