The Federal FSA Program

Qualified Status Change Form

Notification, Election or Change to Enrollment

Name:	**SSN:**
Address:	**Daytime Phone:**
City/State/Zip:	**Email Address:**
Agency:	**Control #: 10779**

❒ **Section 1: Identify the significant event(s) on which my change in election request is based**
Check applicable box(es) to indicate the Qualified Status Change Event(s) that apply to your situation and indicate the date the event occurred. Your change in election(s) must be on account of, and consistent with, your event. In addition, all changes are prospective unless due to the birth, adoption, or placement for adoption of a child as described in the Effective Date of Coverage Change section below. Additionally, you are not permitted to reduce your election for HCFSA or DCFSA to a point where your total allotment for the Plan Year is less than the amount already reimbursed or on deposit in your account for the Plan Year. Also, when modifying your allotment due to a Qualified Status Change, keep in mind that your annual amount cannot be less than $250.00 for either a DCFSA or HCFSA, and cannot exceed $5,000 for the DCFSA or $4,000 for the HCFSA.

To make a change, you must notify SHPS anywhere from 31 days before to 60 days after the date of the event. If you choose to report your Qualified Status Change prior to the date of the event, you must notify SHPS of the actual event date before the change can become effective.

❒ **Change in Status:** (Check all that apply.) **Date Event Occurred: _____**

- ☐ Change in legal marital status
- ☐ Birth of your child
- ☐ Death of your dependent
- ☐ Change in your dependent's eligibility. For example, your child turns age 13 and your child care expenses are no longer eligible for reimbursement, or your spouse begins to work a reduced schedule.
- ☐ Change in cost. For DCFSA, your daycare fee changes by 10% or more; for HCFSA, you had to enroll a new FEHB plan mid-year resulting in a change in cost, or other insurance cost for HCFSA (i.e. for employee, spouse, or employee's dependent).
- ☐ Change in number of tax dependents
- ☐ Adoption or placement for adoption of your child
- ☐ Change in Employment Status (i.e. for employee, spouse, or employee's dependent) that affects eligibility for health insurance benefits.
- ☐ Change in residence required by my employer affecting eligibility (i.e. moving to an area that would require you to elect a new FEHB or other insurance plan.)
- ☐ Change in coverage. For DCFSA only, i.e. change in daycare provider
- ☐ Other (please explain – i.e. LWOP due to military deployment) _____

❒ **Section 2 – Election Change**
As a result of, and consistent with, the Qualified Status Change indicated in Section 1of this form, I am requesting the following:

- **Health Care Flexible Spending Account**
  - Replacement of an existing election with a new election: (Note: the new election must not be less than the total allotments received or expenses previously reimbursed.) *I hereby REVOKE my existing election under the Health Care Flexible Spending Account and make the following election for the current Plan Year: $_____*
  - Election to participate: *I hereby elect to participate in the Health Care Flexible Spending Account Plan. I elect to contribute $_____ for the current plan year.*
  - No change in existing election.

- **Dependent Care Flexible Spending Account**
  - Replacement of an existing election with a new election: (Note: the new election must not be less than the total allotments received or expenses previously reimbursed.) *I hereby REVOKE my existing election under the Dependent Care Flexible Spending Account and make the following election for the current Plan Year: $_____*
  - Revocation of an existing election without a new election: *I hereby REVOKE my existing election under the Dependent Care Flexible Spending Account Plan.*
  - Election to participate: *I hereby elect to participate in the Dependent Care Spending Account Plan. I elect to contribute $_____ for the current plan year.*
  - No change in existing election.

❒ **SECTION 3 - Leave Without Pay (LWOP**)

LWOP is not considered a Qualified Status Change unless it is due to military deployment. However, if you make a Qualified Status Change at the start of a period of LWOP, and you already participate in the Health Care or Dependent Care Flexible Spending Accounts, you have two options for your coverage DURING the LWOP period:

- **Prepay my allotments.** I wish to accelerate my deductions, prior to my leave, without pay to ensure I can submit claims through the end of the Plan Year. I understand that I must visit the FSAFEDS Web site at www.fsafeds.com to record my change in allotments. I understand that this will increase the per pay amount. For DCFSA I understand that if I am not working during my leave, I may not eligible for reimbursement on dependent care expenses.
- **Freeze my account and re-calculate payroll deductions upon my return from leave.** I understand that the expenses I incur during my LWOP status will not be reimbursed unless I return to duty during the Plan Year and have deductions withheld to fulfill my annual election.

❒ **Effective Date of Coverage Change:**

Your change(s) will go into effect the beginning of the pay period that coincides with, or immediately follows, receipt of this form by SHPS. If your requested change is due to the birth or adoption of a child, the change will be effective retroactively to the date of the birth or placement for adoption, based on the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). SHPS will adjust your deductions prospectively.

❒ **Appeal Rights:**

You have the right to appeal a claim for benefits that have been denied by writing to SHPS and requesting reconsideration. You can submit written appeals to:
FSAFEDS Program • PO Box 36880 • Louisville, KY 40233-6880

If you have questions you may visit the FSAFEDS Web site at www.fsafeds.com or call the FSAFEDS toll-free phone line at **1-877-FSAFEDS (372-3337**). Benefits Counselors are available to assist you from 9:00 A.M. to 9:00 P.M. Eastern Time, Monday through Friday. TTY Line: 1-800-952-0450

By signing below, I acknowledge that:

- My compensation will be reduced by an amount I have elected annually under the Federal FSA Program, continuing for each pay period until this agreement is amended or terminated.
- I cannot change or revoke any of these elections as of any date prior to the end of the plan year, unless I experience another Qualified Status Change.
- Any pre-tax elections I have made will reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be slightly decreased.
- Any amounts remaining in my Health Care Flexible Spending Account and/or my Dependent Care Flexible Spending Account after the end of the Plan Year, for which valid expenses have not been incurred, **will be forfeited.**
- All valid claims must be submitted no later than 120 days after the Plan Year ends on December 31.
- Prior to the anniversary date (January 1) each year, I will be offered the opportunity to add, change or stop my elections for the following plan year. If I wish to continue in one or both of the Flexible Spending Accounts, I must make an election each year.

_____ _____

Employee's Signature **Date**