This form must be received by the Benefits Department within 31 calendar days of the mid-year election change event or hire date, whichever is applicable.

SF 4400-CFB # (1-2003)

Supersedes (1-2002) issue

UCI
REIMBURSEMENT SPENDING ACCOUNT
MID-YEAR ELECTION CHANGE FORM

This form must be RECEIVED in the Benefits Department within 31 calendar days of the mid-year election change event in order to enroll or make a change in, or cancel, one or both Accounts.

Name: _____ Social Security Number _____

Home Address: _____
(Include city, state, zip code)

Sandia Organization: _____ Sandia Mail Stop: _____ Sandia Phone #: _____

Mid-Year Election Change Event: _____ Date of Event: _____

Reason for Change (explain why requested change is consistent with and on account of mid-year event)

Important: Refer to the Reimbursement Spending Accounts Summary Plan Description http://www-irn.sandia.gov/hr/policies/Benefits/Health/rsa for definition and applicable criteria regarding mid-year election change events. The change must be consistent with and on account of the mid-year election change event. The change will be effective on the later of the date of the mid-year election change event or the date the Benefits Department receives the completed paperwork. Note that pre-change expenses cannot be reimbursed from post-change coverage.

I wish to enroll in, disenroll from, or change the following Reimbursement Spending Account(s):

Health Care Reimbursement Spending Account ☐ New Account

Annual Amount* _____ ☐ Change to an existing account

Day Care Reimbursement Spending Account ☐ New Account

Annual Amount* _____ ☐ Change to an existing account

* Enter the total new annual amount you desire for the **current** calendar year. For example, if you already are enrolled for $100 in the Health Care Account but would like a new amount of $500, write in "$500." For the Day Care Account, if you want to terminate your Account, write in the word "terminate." If the amount is not evenly divisible by the remaining pay periods, the amount will be rounded to the closest amount to be evenly divisible.

By signing below, I am indicating that the above mid-year election change event did in fact occur on the date indicated and that I wish to make the above change(s) requested.

Employee Signature: _____ Date: _____

If you have any questions, please call Yolanda Miller, (505) 845-9292, Fax: (505) 844-0662.

Mail or fax completed form to MS 1022, Attn: Yolanda Miller

For Benefits Department Personnel only	
Received by:	**Date:**
Enrollment/Change Accepted:	**Date:**
Enrollment/Change Declined:	**Date:**
New Accounts Only - Date SPD Sent:	