COUNTY OF SONOMA FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM
Change in Election Form / Salary Reduction Agreement
Health FSA Plan & Dependent Care Assistance Plan (DCAP)

Employee Name: _____ **EE ID #** _____

Home Address	City	State	ZIP

Department	Work Phone #	Home Phone #

Complete Parts I, II, III, and IV

Part I

1. **ELECTION CHANGE REQUESTED** (*Check Applicable Boxes*) - *Changes cannot be retroactive

   ❑ **Revocation of an Existing Election -** I wish to **REVOKE** my existing election under the:
   ❑ **Health FSA Plan** ❑ **Dependent Care Assistance Plan** **Effective on pay date***: _____

   ❑ **New Election -** Make a new election mid-year (complete and attach an enrollment form)

   ❑ **Change Election -** I wish to change my existing election:
   ❑ **Health FSA Plan** ❑ **Dependent Care Assistance Plan**

   From : **$** _____ **Bi-weekly** **To** **A) $** _____ **Bi-weekly amount effective on pay date *** _____
   $ _____ **Annually** **B)** _____ **= Number of pay dates at new rate**
   C) $ _____ **A times B**

   DCAP: The total on line C, when added to your previous contributions, becomes your new total coverage amount for this plan year. However, the combined total cannot exceed the annual maximum.

   Health FSA: Line C becomes your new coverage amount for any services which take place after this change as long as the combined total of all periods of coverage do not exceed the annual maximum.

Part II

2. **THE CHANGE IN ELECTION EVENT(S) ON WHICH MY REQUEST IS BASED IS/ARE:**

   Check Applicable Box(es) to indicate the change in election event(s) that apply to your situation. Election changes generally cannot be retroactive and must be made **within 31 days** of and consistent with the change in election event, as described in Part III of this form.

   ❑ **A. Change in Status**

   1. Change in Marital Status: **Effective Date of event:** _____
   - ❑ Marriage
   - ❑ Divorce, annulment, or legal separation
   - ❑ Death of spouse

   2. Change in Number of Tax Dependents: **Effective Date of event:** _____
   - ❑ Birth, adoption, or placement for adoption, or termination of adoption placement or proceeding
   - ❑ Death of dependent
   - ❑ Other: _____

   3. Change in Employment That Resulted in Gaining or Losing Eligibility: **Effective Date of event:** _____

Reason	Yourself	Your Spouse or Dependent
❑ Termination of employment	❑	❑
❑ Commencement of employment	❑	❑
❑ Part-time to full-time or full-time to part-time	❑	❑
❑ Temporary to permanent	❑	❑
❑ Strike or lock-out	❑	❑
❑ Commencement of unpaid leave of absence	❑	❑
❑ Return from unpaid leave of absence	❑	❑
❑ Change in work site (which affects coverage)	❑	❑
❑ Commencement of or return from an FMLA leave	❑	❑

   Brief Explanation: _____

4. Change in Eligibility Under an Employer's Plan	**Yourself**	**Your Spouse or Dependent**
❑ Lost eligibility (such as age, student status, marital status)	❑	❑
❑ Gained eligibility (such as age, student status, marital status)	❑	❑

   5. Change in Residence where the current health coverage is not available. ❑ ❑

❑ **B. Certain Judgments, Decrees, and Orders** (applies to Health FSA Plan only); may seek to enroll or increase Health FSA election if order requires coverage under your health plan; decrease or cancel if order requires former spouse or other individual to provide health coverage, and that individual does so. Judgment, decree, or order resulting from divorce, legal separation, annulment, or change in custody requiring coverage for Dependent.

❑ **C. Medicare or Medicaid Entitlement or loss of Entitlement** (Applies to Health FSA Plan only); may seek to enroll, increase, cancel, or reduce coverage

	Yourself	**Your Spouse or Dependent**
❑ Became eligible for Medicare or Medicaid	❑	❑
❑ Lost eligibility for Medicare or Medicaid	❑	❑

❑ **D. Change in Cost (applies to Dependent Care Assistance Plan only)** Provider of care cannot relative of employee
- ❑ Significant cost increase
- ❑ Significant cost decrease

❑ **E. Change in Coverage (applies to Dependent Care Assistance Plan only)**
- ❑ Changed Dependent Care provider or the number of hours of care received.
- ❑ Spouse's open enrollment for Dependent Care Assistance Plan occurs at a different time of year and he/she changed coverage amount.

Part III

3. CONSISTENCY OF CHANGE IN ELECTION EVENT WITH MY REQUESTED ELECTION CHANGE

Generally a change can only be made if the status change results in the employee, spouse, or dependent gaining or losing eligibility and the election change corresponds with the effect on eligibility. *Explain below how the election change(s) that you checked in Part I is/are consistent with the change in election event(s) that you checked in Part II.* You must explain why your requested change is necessary or appropriate as a result of the event you checked in Part II. (e.g.: I'm taking a leave of absence therefore the number of hours of childcare are fewer than expected.) The Administrator of the Plan has final discretion to determine whether the consistency requirement has been satisfied.

Part IV

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must be made **within 31 days of the event** and must comply with the Plan. The Administrator has sole discretion to make this determination. I may appeal the decision in writing within 15 calendar days if my change in participation is denied.

I understand that a change in bi-weekly contribution creates a new period of coverage under the Health FSA plan. Eligible expenses incurred in each separate period of coverage may be reimbursed up to the coverage amount for that period, but in no event shall the combined total reimbursement exceed the annual maximum allowed in the plan.

If approved, I hereby elect the change(s) noted and attest that the change is made on account of and is consistent with the change in election event.

Employee's Signature **Date**

Benefits use only:

❑ ***Accepted and agreed to*** ❑ ***Denied***

Administrator's Signature **Date**

Denied for the following reason:

Original: Benefits Unit

Copy: Employee as confirmation

Date Entered in eP:

Initials:

Qualifying Event Date:

Effective on pay date:

Premium Start Date:

Number of Pay Periods: