



## Change of Election/Termination Form

 **Health FSA**
 **Dependent Care FSA**

### Employee Data (Required)

Employer Name	
Employee Name	
Social Security Number (last 4 digits)	XXX – XX –

### Type of Status Change (Required)

Participants of the 125MAX Flexible Spending Arrangements are entitled to revoke or change benefit elections only under specified circumstances. Elections must be **necessitated by and consistent with** the change in family status and must be acceptable under the regulations issued by the Department of the Treasury. Please identify the type of Status Change incurred. This list is not conclusive. **Complete sections indicated.** Please call 125MAX for assistance in completing this form.

<input type="checkbox"/> <b>Marital Status Change</b> (marriage/divorce) II, III, IV, V Spouse Name: _____ (Same-sex marriage not a qualifying event for Section 125 Plans)  Date of Birth: ___/___/_____ Sex: <input type="checkbox"/> M / <input type="checkbox"/> F  <input type="checkbox"/> <b>Change in Number of Tax Dependents</b> (birth /adoption of a child, or death of a dependent/spouse) II, III, IV, V  <input type="checkbox"/> <b>Commencement of Employment</b> (for employee, spouse or dependents) II, III, IV, V  <input type="checkbox"/> <b>Work Schedule Change</b> (full-time to part-time or vice versa which causes loss of eligibility) II, III, IV, V	<input type="checkbox"/> <b>Dependent Eligibility Change</b> (either satisfying or ceasing to satisfy eligibility requirements) II, III, IV, V  <input type="checkbox"/> <b>Increase or Decrease in the Dependent Care Provider's Monthly Fees</b> (when the provider is not a relative of the employee) II, III, IV, V  <input type="checkbox"/> <b>Decrease in Necessary Hours of Dependent Care Due to Enrollment in School</b> II, III, IV, V  <input type="checkbox"/> <b>Other</b> (list) II, III, IV, V: _____
<input type="checkbox"/> <b>Termination of Employment</b> (employee, spouse, or dependents) I, V      Actual Termination Date: _____	

### I. Termination (Participant signature not required)

Effective Pay Period: _____	Health Year-to-Date: \$ _____	Dep Care Year-to-Date: \$ _____
Amount deducted from last paycheck: _____	Health FSA: \$ _____	Dependent Care FSA: \$ _____

### II. Date of Status Change

Request for Change of Election must be made within 30 days of the date of Family Status change. Please identify the exact date of the Status Change, any additional amounts deducted from the final paycheck, and the year-to-date deductions.

Status Change Date: \_\_\_\_\_ Effective Pay Period: \_\_\_\_\_

### III. Statement of Consistency

IRS guidelines outline that an election change must be "consistent with and on account of" the status change. Please describe why the election change is necessary or appropriate given your status change.

Describe Reason for Change: \_\_\_\_\_

### IV. Election Change Request

Health Expenses	Dependent Care Expenses
<b>New Annual Election:</b> \$ _____ <b>Deduction Amt:</b> \$ _____  <b>Plan Year Maximum:</b> Check with your HR dept for your specific Plan maximum	<b>New Annual Election:</b> \$ _____ <b>Deduction Amt:</b> \$ _____  <b>Calendar Year Plan Maximum:</b> \$ 5,000.00 (set by IRS)
This election is for eligible medical expenses for yourself and/or your spouse/dependents. Premium contributions <b>should not</b> be counted.	This election is for eligible dependent care expenses (daycare, childcare, or elder care). Election <b>should not</b> be used for medical expenses for your dependents.

### V. Verification

**Fax to: 916-605-4013 or email to: [info@125max.com](mailto:info@125max.com)**

I understand my 125MAX Flexible Spending Arrangement election is made for the entire plan year and that it is revocable only under certain circumstances specified by the law. I certify the above qualified Status Change has occurred on the date specified. Further I am requesting a change in my plan election that is consistent with the Status Change indicated above. Participant signature not necessary for termination.

Date:	Participant Signature:
Date:	Employer/HR Signature: