



Mid-Year Election Change Request Form
Flexible Spending Account - FSA

Section I. Employee Information

Name: _____ Date of Birth: _____
Social Security #: _____ Telephone #: _____
Address: _____
Employer: _____ (City) (State) (Zip Code)

Section II. Health Care FSA – Select type of change requested. The requested change must be consistent with the qualifying event and will be effective as described in the plan document only after the event has occurred and a properly completed form has been submitted. Your employer may request documentation to support any of the qualifying events.

Increase/Start a Health Care FSA – please select the qualifying event that has taken place. If this is a new election an enrollment form must also be completed.

- Marriage – to add new spouse to coverage
- Increase in the number of dependents (birth, adoption, etc.)
- Change in employment status that makes me newly eligible for the FSA
- Loss of coverage under Medicare or Medicaid
- Loss of coverage under another FSA (due to divorce, spouse's loss of employment, etc.)

Decrease/Stop my Health Care FSA – please select the qualifying event that has taken place. New annual benefit must not be less than the amount contributed or the amount paid.

- Loss of Spouse – to drop coverage for former spouse
- Decrease in the number of dependents
- Entitlement to Medicare or Medicaid
- Gain of coverage under another FSA

Date of Qualifying Event: _____
(Completed form must be submitted to your benefits department within 30 days of the date of the qualifying event.)

Description of Event: _____

Current Annual Benefit Amount _____

Requested Annual Benefit Amount _____

Section III. Dependent Care FSA - Select type of change requested. The requested change must be consistent with the qualifying event and will be effective as described in the plan document only after the event has occurred and a properly completed form has been submitted. Your employer may request documentation to support any of the qualifying events.

Increase/Start a Dependent Care FSA – please select the qualifying event that has taken place. If this is a new election an enrollment form must also be completed.

- Increase in the cost of dependent care (does not apply for care provided by a relative)
- Increase in coverage for dependent care

Decrease/Stop my Dependent Care FSA – please select the qualifying event that has taken place. New annual benefit must not be less than the amount contributed or the amount paid.

- Decrease in the cost of dependent care
- Decrease in coverage for dependent care

Date of Qualifying Event: _____

(Completed form must be submitted to your benefits department within 30 days of the date of the qualifying event.)

Description of Event: _____

Current Annual Benefit Amount _____

Requested Annual Benefit Amount _____

Section IV. Employee Signature By signing below I agree that the information provided on this form is accurate and complete. I understand that this form is a request to change the amount of my salary redirected on a pretax basis under IRS Section 125 and is subject to approval.

 Signature

 Date

Section V. Approval – This section to be completed by your benefits department. Upon approval, benefits department submits to M&I.

- Form was received within 30 days of the date of the qualifying event.
- Requested change is consistent with the qualifying event.
- Documentation received (if required).
- New annual benefit is not less than the amount contributed or paid.
- Employee Signature

Date form received: _____

Effective date of change: _____

Approved by: _____

Health Care FSA

$$\frac{\text{New annual benefit}}{\text{contributed prior to effective date of change}} = \frac{\text{difference}}{\text{\# of paychecks remaining}} = \frac{\text{new deduction}}{\text{\# of paychecks remaining}}$$

Dependent Care FSA

$$\frac{\text{New annual benefit}}{\text{contributed prior to effective date of change}} = \frac{\text{difference}}{\text{\# of paychecks remaining}} = \frac{\text{new deduction}}{\text{\# of paychecks remaining}}$$