Benefit Resource, Inc.
plans that perform

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS

(PLEASE PRINT CLEARLY)

EMPLOYER:

EFFECTIVE DATE OF CHANGE : / /

A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time

Email Address:
(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

B. FLEXIBLE SPENDING ACCOUNTS (FSAs) *Please enter any changes in FSA election(s) below.*

(Refer to your Plan Highlights for election maximums)	**Per Pay Deduction**	**Plan Year Election**
☐ Medical FSA *Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.*	$	$
☐ Dependent Care FSA	$	$

C. MID-YEAR CHANGE INFORMATION *Please check applicable event.*

NOTE: • *An election can only be changed if the change in status affects eligibility for that coverage.*
• *Any change in election must be consistent with the change in status and the change in eligibility.*

☐ Participant's termination of employment.
☐ Change in employment status of spouse or dependent (including termination or commencement of employment).
☐ Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).
☐ Change in number of tax dependents (including birth, adoption, placement for adoption, death).
☐ Change in work schedule (reduction or increase in hours by employee, spouse or dependent, including a switch between full-time and part-time, a strike or lockout, and commencement of or return from an unpaid leave of absence).
☐ Change in residence or worksite (of employee, spouse, or dependent).
☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).
☐ Change in dependent care cost or provider (for Dependent Care FSA elections only).
☐ Other _____

D. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

By signing and submitting this change form, I authorize all changes as indicated above and understand that any change must be permissible under Internal Revenue Service (IRS) regulations and as defined in the plan. I understand that any expenses paid under this plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I authorize any election amount(s) above to be deducted from payroll as indicated. I understand that unused amounts in any Flexible Spending Account will be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid MasterCard® is associated with my Flexible Spending Account:

- I agree to use the Beniversal Card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the cardholder agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup request to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature: _____ Date: _____ / _____ / _____

E. PAYROLL DEDUCTION INFORMATION *Employer must enter any changes below.*

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other
- **First pay date of new FSA deduction(s):** /____/____
- **Number of pay dates on which new FSA deduction(s) will be taken during this plan year:** _____
- **Health Insurance Coverage Code:** ___ ___ ___ ___ ___ ___ ***This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.***