



Washington Flex (Health Care Spending Account) & Dependent Care Assistance Program (DCAP)

Change Form

You must complete this form within 60 days of your qualifying event to change your FSA and/or DCAP election amount.

Form with fields for Name (Last, First, MI), Social Security Number, Date of Birth, Street Address, City, State, ZIP Code, Daytime Phone, Home Phone, Agency or Higher-Education Institution Name, Employee I.D. (Higher Education only), Date of Qualifying Event, Payroll Effective Date (Internal Use Only).

Type of Qualifying Event—Please select appropriate event(s)

- Checkboxes for various qualifying events: A qualified tax dependent becomes eligible under PEBB rules, A qualified tax dependent no longer meets PEBB eligibility, Employee or eligible dependent has a change in employment status, An eligible dependent loses coverage under a group health plan, Employee or an eligible dependent gains or loses eligibility for Medicare, Began or ended Family Medical Leave Act (FMLA) period, For DCAP only: Child turned age 13, Significant change in the cost of care.

Changes to Flexible Spending Account (FSA) Contributions

- Checkboxes for FSA contribution changes: I wish to change my Flexible Spending Account contributions for 2011, I wish to cancel my Flexible Spending Account contributions.

Benefits Office Use

of Checks Remaining _____ of _____ Per Check Amount _____

Changes to Flexible Spending Account (for FMLA only)

When beginning FMLA:

- Checkboxes for FMLA beginning: I wish to continue my Flexible Spending Account participation while on FMLA, I wish to discontinue my Flexible Spending Account participation while on FMLA.

When ending FMLA and returning to work:

- Checkboxes for FMLA ending: I wish to reinstate my Flexible Spending Account at the same annual amount, I wish to reinstate my Flexible Spending Account at the same per-paycheck amount.

Changes to my Dependent Care Assistance Program (DCAP)

- Checkboxes for DCAP changes: I wish to change my Dependent Care Assistance Plan contributions for 2011, I wish to cancel my Dependent Care Assistance Program contributions.

Benefits Office Use

of Checks Remaining _____ of _____ Per Check Amount _____

I understand:

- Understanding points: I or an eligible dependent has had a qualifying change in status, If I cancel my Flexible Spending Account contributions, The FSA and DCAP benefits, and my rights and obligations under this plan, This form cancels any prior elections I have made under this plan.

Employee signature _____

Date _____

State agency, University of Washington, and Eastern Washington University employees: Fax this form (toll-free) to ASIFlex at 1-877-879-9038 or mail to ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044. All other employees: Please return this form to your benefits office for processing.

Questions? Call ASIFlex toll-free at 1-800-659-3035 (TTY 866-908-6043) or send an e-mail to asi@asiflex.com