



# 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.

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)

- |   |   |
|---|---|
| <input type="checkbox"/> Dependent becomes eligible through marriage, birth, adoption, or the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption or a child has become eligible as an extended dependent through legal custody or legal guardianship.                                   | <input type="checkbox"/> An eligible dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).  |
| <input type="checkbox"/> Dependent no longer meets PEBB eligibility criteria because employee has a change in marital status, including legal separation documented by a court order, an eligible dependent child turns age 26, ceases to be eligible as an extended dependent or as a dependent with disabilities or a dependent dies. | <input type="checkbox"/> Employee or an eligible dependent gains or loses eligibility for Medicare or becomes eligible for a medical assistance program under DSHS, including Medicaid or the children's health insurance program (CHIP) or the subscriber or dependent loses eligibility in such a medical assistance program. |
| <input type="checkbox"/> Employee or eligible dependent has a change in employment status that affects the employee's or a dependent's eligibility for group health coverage.   | <input type="checkbox"/> Began or ended Family Medical Leave Act (FMLA) period.<br>Start date _____ End Date _____  |
- For DCAP only:**  Child turned age 13  Significant change in the cost of care

### Changes to Flexible Spending Account (FSA) Contributions

- I wish to change my Flexible Spending Account contributions for 2011. My annual contribution amount will now be \$\_\_\_\_\_. (Minimum \$240/Maximum \$3,600) My per-paycheck deductions will change accordingly, starting with the first paycheck of the month after this form is approved.
- 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:

- I wish to continue my Flexible Spending Account participation while on FMLA, and I will send after-tax payments to ASIFlex.
- I wish to discontinue my Flexible Spending Account participation while on FMLA. I cannot request reimbursement from my Flexible Spending Account for expenses incurred while on FMLA.

#### When ending FMLA and returning to work:

- I wish to reinstate my Flexible Spending Account at the same **annual** amount. My per-paycheck deduction will increase accordingly.
- I wish to reinstate my Flexible Spending Account at the same **per-paycheck** amount. This will reduce the annual amount I originally elected for 2011.

### Changes to my Dependent Care Assistance Program (DCAP)

- I wish to change my Dependent Care Assistance Plan contributions for 2011. My annual contribution amount will now be \$\_\_\_\_\_. (Maximum of \$5,000). My per-paycheck deductions will change accordingly, starting with the first paycheck of the month after this form is signed.
- I wish to cancel my Dependent Care Assistance Program contributions.

### Benefits Office Use

# of Checks Remaining \_\_\_\_\_ of \_\_\_\_\_  
 Per Check Amount \_\_\_\_\_

#### I understand:

- I or an eligible dependent has had a qualifying change in status, as defined by the Internal Revenue Service, as well as other federal and state rules, which allows me to change my previous Flexible Spending Account and/or Dependent Care Assistance Program election.
- If I cancel my Flexible Spending Account contributions, I cannot claim reimbursement for expenses incurred for the remainder of 2011 unless I have another qualifying event and submit another change form to ASIFlex. (This does not apply to DCAP participants.)
- The FSA and DCAP benefits, and my rights and obligations under this plan, as specified in the *Washington Flex Enrollment Guide* and/or the *DCAP Enrollment Guide* and Washington Administrative Code.
- This form cancels any prior elections I have made under this plan, and cannot be changed except as stated in the *Washington Flex Enrollment Guide* and/or the *DCAP Enrollment Guide* and Washington Administrative Code.

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](mailto:asi@asiflex.com)