

Flexible Spending Account Election Change Form

If you are enrolled in the Avera Health Plans Flexible Spending Account and choose to change the terms of your enrollment, please complete this form. **The form must be returned to Avera Health Plans within 31 days after the date of the qualifying event.**

Employer Name _____

Member Name _____

Social Security Number _____

Effective Pay Period _____

Reason for Change (Qualifying Event):

Marriage, divorce or legal separation

Name change _____

Birth, adoption or death of dependent

Change in amount of deduction: Unreimbursed medical expense from _____ to _____

Dependent care expense from _____ to _____

Loss of dependent status

Change in amount of deduction: Unreimbursed medical expense from _____ to _____

Dependent care expense from _____ to _____

Change in employment for you or spouse (such as part-time to full-time)

Change in amount of deduction: Unreimbursed medical expense from _____ to _____

Dependent care expense from _____ to _____

Other (give details and provide documentation) _____

Change in amount of deduction: Unreimbursed medical expense from _____ to _____

Dependent care expense from _____ to _____

Termination of your employment

If your Flexible Spending Account has a balance at the time of termination, you may still submit claims for services and supplies. The claims must be for services and supplies received during the current contract year before the termination date.

Date of Qualifying Event _____ **Date of Last Payroll Deduction** _____

The amounts you indicated on this election form show the change(s) in contributions you desire as a result of your change in status.

Employee Signature _____ Date _____

➤ **Employee must sign for all changes except termination.**

Employer Signature _____ Date _____