

Flexible Spending Account Qualifying Event Mid-Year Changes



Please print all information

Participant Information					
Employer:				Division:	
Participant Name:			Social Security #:		
Address:				<input type="checkbox"/> Check if new address	
Participant E-mail Address:			<input type="checkbox"/> Check if new email	Daytime Phone #:	() -
Date of Hire:	/ /	Qualifying Event Date:	/ /	Date of Payroll Change:	/ /
Qualifying Event for FSA Mid-Year Enrollment or Change of Current Year Enrollment					
<input type="checkbox"/> Employee Newly Eligible for Benefits – You must also complete the Flexible Spending Account Enrollment Form available from HR					
<input type="checkbox"/> Employee Termination			Date of Last Payroll Deduction:	/ /	
<input type="checkbox"/> Change in Employee's Legal Marital Status			<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Legal Separation
			<input type="checkbox"/> Annulment	<input type="checkbox"/> Death of Spouse	
<input type="checkbox"/> Change in Employee's Number of Dependents			<input type="checkbox"/> Birth	<input type="checkbox"/> Adoption/Placement for Adoption	
			<input type="checkbox"/> Change in Guardianship	<input type="checkbox"/> Death of Dependent	
<input type="checkbox"/> Change in Employee or Spouse's Employment Status Effecting Coverage			<input type="checkbox"/> Termination of Employment	<input type="checkbox"/> Commencement of Employment	
			<input type="checkbox"/> Change from FT to PT or PT to FT		
<input type="checkbox"/> Change in Employee or Spouse's Place of Residence Effecting Eligibility for Coverage					
<input type="checkbox"/> Significant change/reduction in coverage or cost of coverage for employee or covered dependent.					
Qualifying Events Applicable to Dependent Care Accounts ONLY:					
<input type="checkbox"/> Change in Day Care Provider					
<input type="checkbox"/> Change in Day Care Rate					
New Election Amount:					
	Old Election Amount		New Election Amount		
Health Care Account:	Per Pay Period:	\$	Per Pay Period:	\$	
Dependent Care Account:	Annual:	\$	Annual:	\$	
Signatures:					
Participant Signature (Required)			Date		
Employer Signature (Required)			Date		

ACCEPTANCE OF FACSIMILE OR SCANNED SIGNATURES: Document signatures delivered by facsimile or email/pdf are valid and enforceable. Such facsimile or scanned signatures shall have the same force and effect as an original signature.

For fastest results, file claims online at www.member.varipro.com or by using the Varipro Health Cloud app (available in both the Apple App and the Google Play Stores).