UNIVERSITY OF ARKANSAS SYSTEM

FSA CHANGE FORM

All fields are required. Incomplete forms cannot be processed.

SECTION I: EMPLOYEE INFORMATION. Please print legibly.

Full Name *as it appears on your FSA debit card*	Social Security No.	Effective Date of Change (MM/DD/YYYY)

Campus (Please check one):

❑ UACCB ❑ UAM ❑ UAMS ❑ UAPB ❑ PCCUA ❑Other:____

SECTION II. CHANGE REQUESTED

☐	**Change of Name** *New Name:* ____
☐	**Change of Address** *New Address:* ____
☐	**Suspend my payroll salary reduction (MUST COMPLETE SECTION III)**
☐	**Change of Election (MUST COMPLETE SECTION III)** *I elect to change my annual salary reduction from $_________ to $___________ for the Health Care FSA.* *I elect to change my annual salary reduction from $_________ to $___________for the Dependent Care FSA.*

SECTION III. CHANGE IN STATUS (for suspension of payroll salary reduction or change of election)

		Name of Dependent	Date of Event (MM/DD/YYYY)
☐	**Marriage**		
☐	**Divorce**		
☐	**Death of Spouse or Dependent**		
☐	**Birth or Legal Adoption**		
☐	**Ineligible Dependent**		
☐	**Loss of Coverage**		
☐	**Leave of Absence**		
☐	**FMLA**		
☐	**Termination of Employment**		
☐	**Other:** ________________________________		

SECTION IV. AUTHORIZATION AND SIGNATURE

I authorize my employer to adjust my pay as required by my election. I acknowledge that my election is irrevocable and will remain in force throughout the plan year unless there is a Change in Status.

Employee Signature	Date Signed
x	

FOR HR USE ONLY

Signed: ________________

Date: ________________

RETURN THIS FORM TO YOUR HUMAN RESOURCES OFFICE.

REV OCT 2020