

2021 MID-YEAR FSA CHANGE FORM

The Consolidated Appropriations Act of 2021 allows employees to change their Flexible Spending Account (FSA) contribution rate during 2021, without requiring a qualifying change of status event such as a change in marital status or the birth or adoption of a child.

If you currently participate in a Health Care or Dependent Care FSA, and wish to change your annual election, please complete this form and return it to your campus Human Resource Department.

Changes will take effect the 1st of the following month.

- If you are paid monthly, changes will take effect on your next month's paycheck.
- If you are paid bi-weekly or semi-monthly, changes will take effect on the first regular paycheck of the following month.

EMPLOYEE INFORMATION. Please print legibly.	
Full Name	Social Security Number Employee ID Number
Payroll Cycle: <input type="checkbox"/> Bi-weekly (26 pay periods) <input type="checkbox"/> Semi-monthly (24 pay periods) <input type="checkbox"/> Monthly (12 pay periods)	
CHANGE REQUESTED	
SUSPEND my payroll salary reduction (check one or both): <input type="checkbox"/> Health Care FSA <input type="checkbox"/> Dependent Care FSA	
<i>I understand that my year-to-date contribution as of the end of this month will be my new annual election. I attest that my FSA reimbursements and/or debit card transactions so far this year are less than my year-to-date payroll contributions. I understand that I may continue to file claims incurred through the end of the calendar year or until my last day of employment, whichever occurs first.</i>	
<input type="checkbox"/>	CHANGE my Health Care FSA <u>annual</u> election from \$_____ to \$_____. <i>The maximum annual election remains \$2,750 for 2021. I attest that if I am decreasing my annual election, my FSA reimbursements and debit card transactions so far this year do not exceed my year-to-date payroll contributions.</i>
<input type="checkbox"/>	CHANGE my Dependent Care FSA <u>annual</u> election from \$_____ to \$_____. <i>The maximum annual election is the least of: your salary; your spouse's salary; the temporary limit of \$10,500 annually (if married filing joint return or single filing Head of Household); \$5,250 annually (if married and filing separate returns), or your expenses. The \$10,500 annual limit applies ONLY for the 2021 plan year.</i>
AUTHORIZATION AND SIGNATURE	
<i>I authorize my employer to adjust my pay as required by my election. I acknowledge that my election may be irrevocable and will remain in force throughout the plan year unless there is a Change in Status.</i>	
Employee Signature X _____	Date

RETURN THIS FORM TO YOUR HUMAN RESOURCES OFFICE.

FOR HR USE ONLY

Signed: _____

Date: _____