CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS
(PLEASE PRINT CLEARLY)

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF CHANGE : / /

A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / /

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time

Email Address: _____

(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

B. FLEXIBLE SPENDING ACCOUNTS (FSAs) *Please enter any changes in FSA election(s) below.*

(Refer to your Plan Highlights for the type of accounts and election maximums offered by your plan.)

	Per Pay Deduction	Plan Year Election
☐ Medical FSA *Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.*	$ _____	$ _____
☐ Limited Medical FSA *(reimburses dental, vision and/or post-deductible expenses as allowed by your plan)* *Note: You cannot elect this account if you elect a General Medical FSA. You can elect this account if you are covered under an HSA.* Change in level of coverage under health insurance to ☐ Single ☐ Family	$ _____	$ _____
☐ Dependent Care FSA	$ _____	$ _____

C. MID-YEAR CHANGE INFORMATION *Please check applicable event.*

NOTE: • *An election can only be changed if the change in status affects eligibility for that coverage.*
• *Any change in election must be consistent with the change in status and the change in eligibility*

☐ Participant's termination of employment.
☐ Change in employment status of spouse or dependent (including termination or commencement of employment).
☐ Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).
☐ Change in number of tax dependents (including birth, adoption, placement for adoption, death).
☐ Change in work schedule (reduction or increase in hours by employee, spouse or dependent, including a switch between full-time and part-time, a strike or lockout, and commencement of or return from an unpaid leave of absence).
☐ Change in residence or worksite (of employee, spouse, or dependent).
☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).
☐ Change in dependent care cost or provider (for Dependent Care FSA elections only).
☐ Other _____

D. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

By signing and submitting this change form, I authorize all changes as indicated above and understand that any change must be permissible under Internal Revenue Service (IRS) regulations and as defined in the plan. I understand that any expenses paid under this plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I authorize any election amount(s) above to be deducted from payroll as indicated. I understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I agree to use the Beniversal Card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature: _____ Date: _____ / _____ / _____

E. PAYROLL DEDUCTION INFORMATION *Employer must enter any changes below.*

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other _____
- **First pay date of new FSA deduction(s):** ____/____/____
- **Number of pay dates on which new FSA deduction(s) will be taken during this plan year: _____**
- **Change in Health Insurance level of Coverage:** ☐ Single ☐ Family
- **Health Insurance Coverage Code: ___ ___ ___ ___ ___ ___** ***This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.***

The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.
The Beniversal Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. Card accepted at qualified merchants accepting Debit Mastercard. The Bancorp Bank; Member FDIC.