

FAIRFAX COUNTY PUBLIC SCHOOLS CHANGE IN STATUS FORM FOR FLEXIBLE SPENDING ACCOUNTS

Social Security Number:				
Last Name (Please Print)		First Name		MI
Home Address		Street	City	State
Work Phone ()	Home Phone ()		E-mail	

QUALIFIED CHANGE EVENTS: (CHECK AND DATE ALL THAT APPLY)

		for	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
DATE	<input type="checkbox"/> _____	Marriage	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Divorce
	<input type="checkbox"/> _____	Death: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Adoption (or placement for adoption) of child
	<input type="checkbox"/> _____	Birth of child	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Change in Dependent Care provider
	<input type="checkbox"/> _____	Becoming legal guardian of child	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Spouse's unpaid leave <input type="checkbox"/> Begins or <input type="checkbox"/> Ends
	<input type="checkbox"/> _____	Ineligibility of dependent (due to age, marriage)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Employee's unpaid leave <input type="checkbox"/> Begins or <input type="checkbox"/> Ends
	<input type="checkbox"/> _____	Dependent or Spouse Employment: <input type="checkbox"/> Begins or <input type="checkbox"/> Ends	<input type="checkbox"/> _____	Other: _____	
	<input type="checkbox"/> _____	Change from full-time to part-time employment (or vice versa)			

TYPE OF CHANGE REQUESTED

Change Existing Account	Start Account	Terminate Account (Future Medical Expense services will not be reimbursable.)
<input type="checkbox"/> Health Expense Account	<input type="checkbox"/> Health Expense Account	<input type="checkbox"/> Health Expense Account
<input type="checkbox"/> Dependent Care Account	<input type="checkbox"/> Dependent Care Account	<input type="checkbox"/> Dependent Care Account

CALCULATE YOUR NEW PER PAYCHECK DEDUCTIONS

	Health Expense Account	Dependent Care Account	Tax Filing Status PLEASE CHECK ONE
A. Current Total Annual Contribution (if applicable)			<input type="checkbox"/> Married, filing separately [maximum-\$2,500] <input type="checkbox"/> Married, filing jointly [maximum-\$5,000] <input type="checkbox"/> Single, head of household [maximum-\$5,000]
B. New Total Annual Contribution			
	<input type="checkbox"/> Starting on ____ / ____ / ____ Date	<input type="checkbox"/> Starting on ____ / ____ / ____ Date	

Comments: _____

I certify that on the date(s) indicated, I incurred the Change in Status(s)* checked above and therefore wish to change my plan elections as indicated. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my period of coverage. The change in election will be effective on the first day of the month following the date the Change In Status form is received and approved by Fairfax County Public Schools. Expenses incurred before my effective date will not be reimbursed.

Signature _____ Date _____

SEE BACK FOR FURTHER DETAILS

CHANGES DURING THE YEAR

You may change your FSA election mid-plan year only when a qualified Change in Status event has occurred. Experiencing one of the CIS events listed does not automatically permit a mid-plan year election change. To be eligible, status changes must comply with the IRS "general consistency" requirement as stated below. A mid-plan year election change can only be made on a future basis.

TO REQUEST AN ELECTION CHANGE:

1. If you have any questions about the eligibility of a requested change or completing the form, contact FBMC's toll-free Customer Service number listed below.
2. Complete, sign and date the form and submit all copies to FCPS for authorization and processing. The form must be signed and dated within 30 days **after** the date of the event. Forms submitted before the date of the event cannot be accepted.
IMPORTANT: Be sure to submit your form with ample time for it to be processed so that your desired effective date for the change(s) is not delayed.
3. Please send a copy of documentation supporting your mid-plan year election change request. Examples of documentation are marriage licenses, divorce decrees, birth certificates, etc.
4. The effective date of any change(s) will be the first day of the month following the date the form is received and approved by FCPS.
5. If your election change request is denied, you will have 30 days from the date of the denial to file an appeal with FCPS.

CONSISTENCY RULE:

- Generally, an election change satisfies the consistency requirements only if the change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. In addition, for dependent care accounts only, an election change also satisfies the consistency requirements if the election change is on account of and corresponds with a change in status that affects dependent care expenses.

WHERE TO SUBMIT THIS FORM:

When you have completed this form, either

- **FAX** to 571-423-5000
- **Mail** to the Office of Benefit Services, Department of Human Resources, 8115 Gatehouse Road, Suite 2700, Falls Church, VA 22042
- **Pony** to Benefits Processing, Office Benefit Services, Human Resources Center