Hackensack Meridian *Health*

DEPENDENT CARE FSA PLAN
QUALIFIED LIFE EVENT CHANGE FORM

INSTRUCTIONS

Employees are provided with the opportunity to change their contributions to a Dependent Care Flexible Spending Account (FSA) if you have experienced a change in your dependent care provider or their cost. **Please complete this form if you are:**

> Newly electing a Dependent Care FSA because you have enrolled a child/adult dependent with a dependent care provider

> Increasing or decreasing your Dependent Care FSA because your cost for services has changed

> Discontinuing participation Dependent Care FSA because your child/adult dependent is no longer enrolled with a provider

Once your form is complete, please return it to Julia.Vega@hackensackmeridian.org**.**

EMPLOYEE PROFILE

Name _____ **SSN (Last four digits only)** XXX – XX – _____

Address _____ **Date of Hire** _____

_____ **Date of Birth** _____

City, State Zip _____ **Home Phone #** _____

DEPENDENT CARE FSA

To elect a Dependent Care FSA, please indicate below the **per pay amount** that you would like to contribute. The maximum annual pre-tax Dependent Care FSA contribution amount is $5,000.

☐ **YES**, I would like to elect the **Dependent Care FSA**. My **per pay** contribution amount is $_____.

☐ **YES**, I would like INCREASE/DECREASE my **Dependent Care FSA**. My **new per pay** contribution amount is $_____.

☐ **NO**, I wish to WAIVE/DISCONTINUE participation in the **Dependent Care FSA**.

AUTHORIZATION

I authorize my employer to reduce my salary by the agreed amounts indicated on this form on a pre-tax basis for the Dependent Care Flexible Spending Account benefit I selected above. **I understand that I can change my election on a monthly basis. I also understand that if I do not submit another Change Form, the elections indicated above are applicable for the remainder of the current plan year and each plan year thereafter until my employment terminates or I file another form indicating that I wish to change my contribution or discontinue participation.** Any monies remaining in my account will be rolled forward into the next year until termination of my employment. I also understand that my employee and employer contributions to Social Security may be reduced as my contributions for the benefits elected on this form are taken on a pre-tax basis.

_____ _____

Signature **Date**