MidAmerica

FSA Change of Status Election Form

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER.

STEP 1 Participant Information

Employer

Date of Birth (mm/dd/yyyy)

First Name

Last Name

M.I.

Social Security Number

Mailing Address

City

State

Zip

Telephone

Email Address

STEP 2 Type of Change

NOTE: Enter effective date of coverage:

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year may be forfeited depending on your plan design. Additional rules regarding when expenses must be incurred in order to be eligible for reimbursement may also vary depending on your unique FSA. For more details on your FSA, review your Plan Highlights. You can download your Plan Highlights by logging into your account at www.myMidAmericaJourney.com.

Benefit Type	Current Annual Election	Current Per Pay Period Withholding	New Annual Election	New Per Pay Period Witholding
Health Care Reimbursement	$	$	$	$
Dependent Care Reimbursement	$	$	$	$

STEP 3 Reason for Change (Qualifying Event)

NOTE: Enter effective date of change in status*:

Valid qualifying events include, but are not limited to (choose one):

- ☐ **Change in Employment Status |** Beginning/end of employment of a spouse resulting in a gain or loss of insurance coverage.
- ☐ **Change in Legal Marital Status|** Marriage, divorce, or death of a spouse.
- ☐ **Change in Number of Tax Dependents |** Birth, adoption/placement for adoption, gain/loss of dependent eligibility, or death of a dependent.
- ☐ **Change in Insurance Coverage, Cost, or Provider |** This option only applies to dependent care.
- ☐ **Gain or Loss of Other Group Health Coverage |** Medicare/Medicaid, COBRA
- ☐ **Judgement, Decree, or Court Order**
- ☐ **Unpaid Leave of Absence**
- ☐ **Change in Employment Type |**Changing from part-time to full-time employment or from full-time to part-time employment.

*You must make your election change within 30 days of the qualifying event.

Important note on documentation: You must submit supporting documentation corresponding with the qualifying event, such as a marriage, birth or death certificate; divorce decree; letter from employer substantiating employment status or change in coverage; letter from childcare provider substantiating change in cost or provider.

STEP 4 Participant Certification & Signature

I hereby amend my Flexible Benefits Plan election; therefore, I authorize my Employer to reduce my wages on a pre-tax basis during each payroll period in the amount noted above. I understand this election will be in effect for only the current plan year. I understand I must complete each year. I understand that I cannot revoke or change this election during the Plan Year unless there is another change in status qualifying event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Plan Highlights. I understand that I must submit a claim and appropriate substantiating documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Account Plan for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

▶ Participant Signature

Signature Date (mm/dd/yyyy)

For employer use only: Employers sponsoring the FSA may submit this form through the Employer Upload Site located at https://www.mymidamerica.com/file-upload/employers/. Select *Employer File Upload*, then *Census.*