

**City of Tacoma / Flexible Spending Account Plan  
Change in Election Form**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

*[Check Applicable Box]*

**REVOCAION OF AN EXISTING ELECTION**

Effective \_\_\_\_\_, I hereby REVOKE my existing election under the City of Tacoma Flexible Benefits Spending Plan.

Type of coverage being revoked [my prior election for all other types of coverage remains in effect]:

- Health insurance
  - myself
  - spouse
  - dependent(s) \_\_\_\_\_
- Dependent Care FSA
- Health Care FSA
- Other \_\_\_\_\_

**NEW ELECTION**

Effective \_\_\_\_\_, \* I hereby make a new election under the City of Tacoma Flexible Benefits Spending Plan.

My revocation/new election is on account of and conforms with the change in status or the change in cost or coverage.

**Check the appropriate box** to indicate a Change in Status or a Change in Cost or Coverage. One or more of the following events listed below may qualify you to change your coverage election during the Plan Year. Changes generally cannot be retroactive and must be made on account of and conform with the events indicated. As a general rule, the consistency requirement will not generally be met for a Change in Status Event unless the event affects eligibility for the coverage sought to be changed under this Plan (or an employer-provided plan of your spouse or dependent). The Plan Administrator has final discretion to determine whether the eligibility requirement has been satisfied.

**Changes in Status**

• **Change in Marital Status**

- Marriage
- Divorce or Annulment
- Legal Separation
- Death of Spouse

• **Change in Number of Dependents**

- Birth
- Adoption
- Placement for Adoption
- Death of Dependent

• **Change in Employment Status That Affects Eligibility**

- Termination of Employment
- Commencement of Employment
- Part-time to Full-time
- Full-time to Part-time
- Strike or Lock-Out
- Commencement of unpaid leave of absence
- Return from unpaid leave of absence
- Change in Worksite
- Other (Salary to Hourly, etc.)

	You	Your Spouse or Dependent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• **Change in Spouse or Dependent's Eligibility Under an Employer's Plan**

- Loses eligibility (age, marital status)
- Gains eligibility (age, marital status)

• **Change in Residence Affecting Eligibility**

	You	Your Spouse or Dependent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Changes in Cost or Coverage**

*[Note: Changes in Cost or Coverage do not allow for changes to your Health FSA.]*

- **Significant Cost Increase In Your or Your Dependent’s Coverage**
- **Significant Curtailment of Your or Your Dependent’s Coverage**
- **Addition or Elimination of Benefit Package Option Under Your or Your Dependent’s Employer’s Plan**
- **Change in Coverage Or Open Enrollment of Spouse or Dependent Under Other Employer’s Plan**

Please explain the Change in Status or Change in Cost or Coverage event(s) marked above on which you are basing your request for a mid-year coverage change and describe how the requested change is consistent with the event.

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I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer’s plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

**I Hereby Elect the Change(s) Noted on this Election Form and Attest That the Change Is Made On Account of and Conforms With the Change in Status or Change in Cost or Coverage Event.**

\_\_\_\_\_  
Employee’s Signature

\_\_\_\_\_  
Date

*Accepted and agreed to:*

\_\_\_\_\_  
Plan Administrator’s Signature

\_\_\_\_\_  
Date

\* This revocation/new election will not be effective prior to January 1 following receipt of this form by the Plan Administrator unless it is made because of a Change in Status or a change in cost or coverage. (A Change in Status includes (1) a change in your legal marital status; (2) a change in the number of your tax dependents; (3) a change in your, your spouse’s, or your dependent’s employment status; (4) a change such that your dependent satisfies or ceases to satisfy dependent eligibility requirements; and (5) a change in your, your spouse’s, or your dependent’s residence. A change in the cost or coverage of your benefits includes (1) a significant cost increase; (2) a significant curtailment of coverage; (3) the addition or elimination of a benefit package option; and (4) a change in the coverage of your spouse or dependent under his or her employer’s plan.) The change also must be on account of and conform with the change in status or the change in cost or coverage. In no event may the revocation/new election be effective prior to the first pay period beginning after this form is completed and returned to the Administrator of the Plan, unless a new dependent is being added to health insurance coverage pursuant to HIPAA Special Enrollment rights (newborn or newly adopted child), in which case the new election may be consistent with the new health insurance election.