Flexible Spending Plan Change Form

Employee Name: _____

Employer: _____

Soc. Sec. Number: _____

Address: _____

_____

Please change my election for the remainder of this plan year as indicated below. The change in election will be effective the first of the month following the date this form is signed.

	Per Pay Check Election		**Annual Election**	
	Change from	To	Change from	To
Healthcare FSA	_____	_____	_____	_____
Dependent Care	_____	_____	_____	_____

Date of Event _____

Reason for Change (circle)

1) Marital Status Change: Marriage Divorce Death Annulment Legal Separation

2) Number of Dependents: Birth Adoption Death Marriage (of dependent)
Military Child no longer an eligible dependent
Child turned 13 (Dependent Care only)
Other _____

3) Daycare Provider: Change in Provider Change in Cost

4) Change in Employment Status — Explain: _____

5) Judgment, Decree, or Court Order — Explain: _____

6) FMLA Begin/End (circle one)

7) COBRA event — Explain: _____

_____ _____
Employee Signature Date

Email the completed form to CIS Benefits at EmployeeBenefits@cisoregon.org or fax to 503-763-3900.