Pima County Government
Flexible Spending Account (FSA)
Change in Benefit Election

Employee Name: _____

Pima County Employee ID Number (EIN): _____

Address: _____

_____

Reason for Change (check): **Date of Event** _____

1) Marital Status Change Marriage ☐ Divorce ☐ Death ☐ Annulment ☐ Legal Separation ☐
2) Number of Dependents Birth ☐ Adoption ☐ Death ☐ Marriage (of dependent) ☐
Age ☐ Student Status ☐ Military ☐ Child turned 13 (Dependent Care only) ☐

Other _____

3) Change in Employment Status _____
(Explanation)

4) Change Dependent Care Provider _____
(From ⟶ To)

5) Judgment, Decree, or Court Order _____
(Describe)

6) FMLA Check one: Begin ☐ End ☐

7) COBRA event _____
(Describe)

Explanation if required _____

	Deduction Per Check		Annual Plan Election	
	Current Amt	New Amt	Old Total	New total
Limited Purpose FSA (G1)	_____	_____	_____	_____
Health Care FSA (G2)	_____	_____	_____	_____
Dependent Care FSA (G3)	_____	_____	_____	_____

I certify that the above event has occurred that caused the change in my election for the remainder of this plan year.

_____ _____
Employee Signature Date

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Departmental Benefits Representative Use Only

Effective Date of New Paycheck Deduction _____

-OR-

End of Employment on _____ _____

Last paycheck issued on _____ Departmental Benefits Representative Signature

CHG-FLEX 2014/2015