



# FSA CHANGE FORM

All fields are required. Incomplete forms cannot be processed.

<b>SECTION I: EMPLOYEE INFORMATION. Please print legibly.</b>		
Full Name as it appears on your FSA debit card	Social Security No.	Effective Date of Change (MM/DD/YYYY)
Campus (Please check one):		
<input type="checkbox"/> ASMSA	<input type="checkbox"/> CES	<input type="checkbox"/> UAF
<input type="checkbox"/> WRI	<input type="checkbox"/> PCCUA	<input type="checkbox"/> Other: _____
<input type="checkbox"/> UACCB		
<input type="checkbox"/> UALR		
<input type="checkbox"/> UAM		
<input type="checkbox"/> UAMS		
<input type="checkbox"/> UAPB		
<b>SECTION II. CHANGE REQUESTED</b>		
<input type="checkbox"/>	<b>Change of Name</b> New Name: _____	
<input type="checkbox"/>	<b>Change of Address</b> New Address: _____	
<input type="checkbox"/>	<b>Suspend my payroll salary reduction (MUST COMPLETE SECTION III)</b>	
<input type="checkbox"/>	<b>Change of Election (MUST COMPLETE SECTION III)</b> I elect to change my annual salary reduction from \$_____ to \$_____ for the Health Care FSA. I elect to change my annual salary reduction from \$_____ to \$_____ for the Dependent Care FSA.	
<b>SECTION III. CHANGE IN STATUS (for suspension of payroll salary reduction or change of election)</b>		
	Name of Dependent	Date of Event (MM/DD/YYYY)
<input type="checkbox"/>	Marriage	
<input type="checkbox"/>	Divorce	
<input type="checkbox"/>	Death of Spouse or Dependent	
<input type="checkbox"/>	Birth or Legal Adoption	
<input type="checkbox"/>	Ineligible Dependent	
<input type="checkbox"/>	Loss of Coverage	
<input type="checkbox"/>	Leave of Absence	
<input type="checkbox"/>	FMLA	
<input type="checkbox"/>	Termination of Employment	
<input type="checkbox"/>	Other: _____	
<b>SECTION IV. AUTHORIZATION AND SIGNATURE</b>		
I authorize my employer to adjust my pay as required by my election. I acknowledge that my election is irrevocable and will remain in force throughout the plan year unless there is a Change in Status.		
Employee Signature	Date Signed	
<b>x</b>		

**RETURN THIS FORM TO YOUR HUMAN RESOURCES OFFICE.**

FOR HR USE ONLY
Signed: _____
Date: _____

