STATE OF NEW MEXICO ELECTION CHANGE FORM

HEALTHCARE AND/OR DEPENDENT CARE FLEXIBLE SPENDING BENEFITS

ADMINISTERED BY ERISA ADMINISTRATIVE SERVICES, INC.

As mandated by the Internal Revenue Code Regulations, changes to a Health Care or Dependent Care Spending Account can only be made during a qualified event change in status (QE). Changes to elections become effective on the first of the month following either the event or the request to change elections, whichever comes later.

All changes due to a QE must be made within 31 days of the effective date of the event. Documentation for the event must be submitted at the time of the change request and must include the name of the employee requesting the change or the name of one of their dependents, as well as the date the change becomes effective.

To request a change in your Health Care and/or Dependent Care Flexible Spending Account election, complete the following page and submit the required documentation as detailed below.

FSA Qualifying Events and Required Documents:

Qualifying Events for Changes to Health and/or Dependent Care:

1) Marriage – Marriage Certificate
2) Divorce/Annulment – Divorce or Annulment papers
3) Death of Spouse or Dependent – Death Certificate
4) Birth, Adoption, or placement of adoption of a child – Birth Certificate or Adoption Paperwork
5) Gain or loss of eligibility and Medicare/Medicaid coverage – letter showing gain or loss of coverage, including name of person receiving coverage and date effective
6) Dependent Satisfies or Ceases to Satisfy Eligibility – include explanation of change in eligibility and letter showing change
7) Change in Employment Status of Employee – verifiable through SHARE
8) Change in Employment Status of Spouse or Dependent – letter from employer showing date of change in employment
9) FMLA Begins/Ends – notice from employer/verify in SHARE

Qualifying Events for Changes to Dependent Care ONLY:

10) Cost Change of Dependent Care – letter from care provider showing change in cost and date of effect
11) Change of Dependent Care Provider – letter showing acceptance to program or drop from program
12) Child turns 13 and is no longer eligible for Dependent Care – verifiable through SHARE, OR birth certificate

Please return this form to:

Erisa Administrative Services, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110-6726
Email: sonm@easitpa.com

Phone: (505) 244-6000
Toll Free: (855) 618-1800
Fax: (505) 244-6009

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Erisa Administrative Services, Inc.

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ADMINISTERED BY ERISA ADMINISTRATIVE SERVICES, INC.

Please Print or Type – Your name must match your legal name as reflected on your paycheck

Employee Name	SSN	Date of Birth
Mailing Address		
City	State	Zip
Email Address	Branch/Agency Number	Employee ID

I understand that I may change my Health Care Flexible Spending Account or Dependent Care Spending Account Election(s) if I experience a qualified event change in status as mandated by Internal Revenue Code Regulations. I certify that the following qualified change in status has occurred.

Please indicate the nature of the event below: Effective Date: _____

- ☐ Marriage
- ☐ Divorce/Annulment
- ☐ Death of Spouse or Dependent
- ☐ Birth, Adoption, or placement of adoption of a child
- ☐ Gain or loss of eligibility and Medicare/Medicaid coverage
- ☐ Dependent satisfies or ceases to satisfy eligibility
- ☐ Change in Employment Status of Employee
- ☐ Change in Employment Status of Spouse or Dependent
- ☐ Cost Change of Dependent Care (only if provider not a relative)
- ☐ Change of Dependent Care Provider
- ☐ Child turns 13 and is no longer eligible for Dependent Care
- ☐ FMLA Begins/End
  End Date: _____

I hereby certify that the above event has occurred and agree that this change in election has been the result of and is consistent with the event indicated above. If electing a change in election, the new election amount will be effective for expenses incurred the first of the month following the later of: 1) the date of the event, or 2) the date this form is signed. I understand that this change in election will remain in effect throughout the remainder of the current plan year unless there is another qualified change.

- ☐ I elect to change my previous election in the **Health Care FSA**. My new annual election for the year is $_____. I understand that my pay period deductions will be modified accordingly. The minimum annual deduction for Health Care is $130.00 and the maximum is $2,850.00.
- ☐ I elect to change my previous election in the **Dependent Care Spending Account**. My new annual election for the year is $_____. I understand my pay period deductions will be modified accordingly. The minimum annual deduction for Dependent Care is $130.00 and the maximum is $5,000.00.
- ☐ I elect to stop having my pay reduced on a pre-tax basis for **Health Care**.
- ☐ I elect to stop having my pay reduced on a pre-tax basis for **Dependent Care**.

_____ _____

Employee Signature Date

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