

STATE OF NEW MEXICO ELECTION CHANGE FORM

HEALTHCARE AND/OR DEPENDENT CARE FLEXIBLE SPENDING BENEFITS

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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Divorce/Annulment | <input type="checkbox"/> Death of Spouse or Dependent |
| <input type="checkbox"/> Birth, Adoption, or placement of adoption of a child | <input type="checkbox"/> Gain or loss of eligibility and Medicare/Medicaid coverage | <input type="checkbox"/> Dependent satisfies or ceases to satisfy eligibility |
| <input type="checkbox"/> Change in Employment Status of Employee | <input type="checkbox"/> Change in Employment Status of Spouse or Dependent | <input type="checkbox"/> Cost Change of Dependent Care (only if provider not a relative) |
| <input type="checkbox"/> Change of Dependent Care Provider | <input type="checkbox"/> Child turns 13 and is no longer eligible for Dependent Care | <input type="checkbox"/> 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 \$2,750.00.
- 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

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



Erisa Administrative Services, Inc.