

STATE OF NEW MEXICO ELECTION CHANGE FORM
HEALTHCARE AND/OR DEPENDENT CARE FLEXIBLE SPENDING BENEFITS
ADMINISTERED BY EASI GOV, 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 \$3,400.00 as of 2026.
- ☐ 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 \$7,500.00
- ☐ 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:



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Email: FSA@easitpa.com

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