CS-1784
Rev 10/2020

State of Michigan
Civil Service Commission
EMPLOYEE BENEFITS DIVISION
Flexible Spending Accounts
Capitol Commons Center, 4th Floor
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
800-505-5011

☐ **General Purpose Health Care**

☐ **Limited Purpose Health Care**

☐ **Dependent Care**

FLEXIBLE SPENDING

LIFE EVENT / ELECTION CHANGE FORM

Instructions: Complete this form to report a change in status in either the Health Care or Dependent Care Flexible Spending Account for the current calendar year. Documentation must be provided within 31 days of the qualifying life event in order for the change to be processed. Sign and date the form, attach supporting documentation, retain a copy of the form and the supporting documentation for your records, and mail to the address above or fax to 517-284-0078. A portion of this information is protected by federal privacy laws and/or state confidentiality requirements. **Do not use this form for enrollment.**

PLEASE PRINT OR TYPE

Name		**Daytime Phone** **Ext.**	
Home Address		**Employee ID Number**	
City		**State**	**Zip Code**
State E-mail Address			
Current Biweekly Deduction $	**New Biweekly Deduction** $	**Number of Pay Periods For Deduction** (1 to 26)	

Life Event (Check one below):	**Date of Event**	**Documentation Needed:** (Please send copies)
☐ **1. Birth or Adoption of Child**		**Birth Certificate/ Legal Documentation**
☐ **2. Death of Dependent or Spouse**		**Death Certificate**
☐ **3. Gain or Lose Custody of Dependent**		**Legal Documentation**
☐ **4. Addition of Incapacitated Adult or Child to Household**		**Documentation to Certify Incapacitation**
☐ **5. Legal Separation**		**Legal Documentation**
☐ **6. Divorce**		**Divorce Decree**
☐ **7. Marriage**		**Marriage License**
☐ **8. Significant Change in Dependent Care**		**Detailed Explanation**
☐ **9. Change in Employment Status**		**Documentation from Employer**
☐ **10. Other, Specify: _____**		**Specified by Employee Benefits Division**

I authorize the State of Michigan to reduce my gross biweekly salary in the amount specified above in the New Biweekly Deduction box.

I understand that according to Federal Regulation, any money remaining in my account at the end of the year and its corresponding grace period must be forfeited.

I certify that the information provided on this form is true and complete. I understand that any misstatement or falsification of material facts will result in my removal from the Spending Account, and may cause an IRS and/or state audit with possible additional tax, interest, and penalties due.

Employee's Signature	**Date**