CS-1784

State of Michigan
Civil Service Commission
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
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☐ **General Purpose Health Care**

☐ **Limited Purpose Health Care**

☐ **Dependent Care**

FLEXIBLE SPENDING ACCOUNT (FSA)
QUALIFYING LIFE EVENT ENROLLMENT / CHANGE FORM

Note: New employees must contact MI HR Service Center at 877-766-6447 within 31 days of hire date to enroll in FSAs.

Instructions: Complete this form to report a change in status or to request a midyear enrollment in either your Health Care or Dependent Care Flexible Spending Account for the current calendar year. **Midyear enrollments and qualifying life event (QLE) changes must occur within 31 days of the event; (e.g., birth of child, change in marital status, etc.), and be submitted with supporting documentation.** Documentation must be provided within 31 days of the QLE in order for the change to be processed. Sign and date the form, include supporting documentation, retain a copy for your records, and submit to Employee Benefits Division via one of the methods listed above.

Name	**Daytime Phone** **Ext.**
Employee ID Number	**State E-mail Address**

AUTHORIZED PAYROLL DEDUCTIONS

Enter the total annual amount (referred to as Annual Goal) you're requesting for your eligible FSA expenses beginning with the effective date of this enrollment through December 31st of the current calendar year.

The amount you enter cannot exceed the Annual Goal amount as defined in the FSA Plan Booklet on www.mi.gov/FSA and will be divided evenly and deducted via pre-tax payroll deductions over the remaining biweekly pay periods in the current calendar year.

Enter Requested Annual Amount (Annual Goal)

$

Qualifying Life Event: (check one below)	**Date of Event**	**Documentation Needed: (submit 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. Divorce / Legal Separation**		**Divorce Decree / Legal Documentation**
☐ **6. Marriage**		**Marriage License**
☐ **7. Significant Change in Dependent Care**		**Detailed Explanation**
☐ **8. Change in Employment Status**		**Documentation from Employer**
☐ **9. Other, Specify:** _____		**Specified by Employee Benefits Division**

I authorize the State of Michigan to reduce my gross salary in the amount specified above. I understand I am making a binding election for the remaining calendar year and authorize the State of Michigan to adjust my pay accordingly.

I certify that I have read the rules governing contributions and reimbursements as described in the FSA Plan Booklet and I understand:

1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents.

2) I will not seek reimbursement through any other source.

3) I will collect and maintain sufficient documentation to validate the foregoing.

4) That any amounts remaining in my FSA after the claim submission deadline or above any applicable Health Care FSA carryover amount must be forfeited.

5) That it is my responsibility to make sure that the annual amount specified on this enrollment form is accurate.

6) That my biweekly deduction may not be stopped or changed during the year except in the case of an IRS-approved change in status.

7) The information provided on this form is true and complete.

I agree and understand that any misstatement or falsification of material facts will result in my removal from the FSA, may cause an IRS and/or state audit with possible additional tax, interest, and penalties; which may result in civil and/or criminal prosecution; and may jeopardize my employment status with the State of Michigan.

Employee's Signature	**Date**