CS-1784
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State of Michigan
Civil Service Commission
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
800-505-5011
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☐ **General Purpose Health Care**

☐ **Limited Purpose Health Care**

☐ **Dependent Care**

FLEXIBLE SPENDING ACCOUNT QUALIFYING LIFE EVENT / ELECTION CHANGE FORM

Instructions: Complete this form to report a change in status in either your 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, include supporting documentation, retain a copy for your records, and submit to Employee Benefits Division via one of the methods listed above. A portion of this information is protected by federal privacy laws and/or state confidentiality requirements. **Do not use this form for enrollment.**

Name	**Daytime Phone** **Ext.**	
Home Address	**Employee ID Number**	
City	**State**	**Zip Code**
State E-mail Address		

Enter New Annual Amount
$

Qualifying Life Event (check one below):	Event Date:	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
☐ 6. Divorce / Legal Separation		Divorce Decree / Legal Documentation
☐ 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 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