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 $3,200.00 as of 2024.
- ☐ 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:

EASI Gov

EASI GOV, Inc.
1200 San Pedro Dr. NE
Albuquerque, NM 87110-6726
Email: FSA@easitpa.com

Phone: (505) 244-6000
Toll Free: (855) 618-1800
Fax: (505) 244-6009