STATE OF NEW MEXICO ELECTION CHANGE FORM

HEALTHCARE AND/OR DEPENDENT CARE FLEXIBLE SPENDING BENEFITS

ADMINISTERED BY COMPUSYS/ERISA

Please Print – Your name must match your legal name as reflected on your paycheck.

Employee Name: _____ Male/Female: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____ Branch/Agency Number: _____

E-mail address: _____ Employee ID_____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

I understand that I may change my Health Care 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.

☐ **Marriage Please provide the date of the event_____**	☐ **Gain or loss of eligibility and coverage under Medicare/Medicaid**	☐ **Change in Employment Status of Employee Explain_____**	☐ **Change of Dependent Care Provider**
☐ **Divorce/Annulment Please provide the date of the event_____**	☐ **Birth, Adoption or placement of adoption of a child. Please provide the date of the event_____**	☐ **Change in Employment Status of Spouse or Dependent. Explain_____**	☐ **Child turns 13 on _____ and is no longer eligible for Dependent Care**
☐ **Death of Spouse or Dependent. Please provide the date_____**	☐ **Dependent satisfies, or ceases to satisfy eligibility Explain_____**	☐ **Cost Change of Dependent Care (only if provider not a relative)**	☐ **FMLA Begins/Ends Please provide the start/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 a change in election is, 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 Flexible Spending Account. My annual election for the plan is $_____, and now will be $_____. I understand that my pay period deductions will be modified accordingly. The minimum annual deduction for Health Care is $130.00, the maximum is $2600.00.**

☐ **I elect to change my previous election in the Dependent Care Flexible Spending Account. My annual election for the plan year is$_____, and will now be $_____. I understand my pay period deductions will be modified accordingly. The maximum annual deduction for Dependent Care is $5000.00.**

☐ **I elect to stop having my pay reduced on a pre-tax basis for Health Care/Dependent Care (please circle the benefit you wish to drop.**

_____ _____

Employee Signature **Date**

Please return this form to: Erisa Administrative Services, Inc.
1200 San Pedro NE
Albuquerque, NM 87110-6726
Phone: (505) 244-6000, Toll free: (855) 618-1800
Fax: (505) 244-6009
E-mail: sonm@easitpa.com

Compusys/Erisa Group