The Health Care Flexible Spending Account Program is a division of the Office of Labor Relations' Pre-Tax Benefits Program

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) PROGRAM
QUALIFYING EVENT MID-YEAR CHANGE FORM

40 Rector Street, 3rd Floor, New York, NY 10006
Tel: (212) 306-7760 TTY: (212) 306-7629
nyc.gov/html/olr

HCFSA

Do not write in this box

Agency Payroll Code: ____ ____ ____ ____

Plan Year: _____

1) EMPLOYEE (PARTICIPANT) INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:

Home Address - Number and Street:	Apt. No.:	City:	State:	Zip Code:

Agency Name (Not Division):	Home Phone Number (Area Code): ( )	Work Phone Number (Area Code): ( )

2) PLEASE INDICATE QUALIFYING EVENT INCURRED AND ATTACH APPROPRIATE DOCUMENTATION

QUALIFYING EVENT*	DOCUMENTATION
☐ Marriage	☐ Marriage certificate
☐ Birth of a child	☐ Birth certificate
☐ Adoption of a child	☐ Adoption agreement
☐ New employee	☐ Letter from employer/agency

* The Participant has the burden of proof to show that the Qualifying Event is acceptable under the Plan. The Plan Administrator reserves the right to request additional information. The Plan Administrator has, among other duties, the power and duty to interpret the Qualifying Event and to resolve ambiguities, inconsistencies and omissions.

3) PLEASE INDICATE THE CHANGE YOU WISH TO MAKE (Please complete an FSA Enrollment/Change Form)

The change you wish to make must be consistent with your Qualifying Event and described on the Enrollment/Change Form, which you must return with this form within 31 days of the Qualifying Event.

☐ Start account

☐ Increase goal amount to: $ _____

4) EMPLOYEE (PARTICIPANT) SIGNATURE

This is to certify that on _____, 20 _____ I incurred the Qualifying Event indicated above and, therefore, wish to modify my benefits as indicated. I understand that the change(s) in benefits requested must be consistent with the Qualifying Event, and that I must provide approved documentation of all change(s). The effective date of the change will be the date the forms are received by the Plan Administrator or the date of my first payroll deduction if I become eligible after the beginning of the Plan Year.

✍Signature _____ Date _____

Send the FSA Enrollment/Change Form with this form and all documentation within 31 days of the Qualifying Event to:

Flexible Spending Accounts Program
HCFSA
40 Rector Street, 3rd Floor
New York, NY 10006

OFFICE USE ONLY (Do not write in this box)

Approved date: _____ Effective date: _____

Payroll: _____

Database: _____

Denied by: _____ Sent: / /

Pending documentation: _____

Notes: _____