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

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) PROGRAM
2009 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/olr

Do not write in this box

Agency Payroll Code: ____ ____ ____ ____ ____

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 and employee's tax return showing eligible dependents
❏ 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

The change you wish to make must be consistent with your Qualifying Event and described on the FSA 2009 Enrollment/Change Form, which you must return with this form within 30 days after the Qualifying Event.

❏ Start account *(Please complete an FSA 2009 Enrollment/Change Form)*

❏ Add dependent

❏ 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 2009 Enrollment/Change Form with this form and all documentation within 30 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: ______________________

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