



HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) PROGRAM 2010 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



All Qualifying Events **MUST** be submitted with appropriate documentation in order to be processed.

DO NOT WRITE IN THIS BOX				
Agency Payroll Code				

1) EMPLOYEE (PARTICIPANT) INFORMATION (Please type or print clearly.)				
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
<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce/legal separation/annulment <input type="checkbox"/> Death (<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent) <input type="checkbox"/> Birth of a child <input type="checkbox"/> Adoption of a child <input type="checkbox"/> New employee <input type="checkbox"/> Employee returning from approved unpaid leave of absence taken during the Open Enrollment Period	<input type="checkbox"/> Marriage certificate <input type="checkbox"/> Divorce decree/separation agreement/annulment decree <input type="checkbox"/> Death certificate <input type="checkbox"/> Birth certificate <input type="checkbox"/> Adoption agreement and employee's tax return showing eligible dependents <input type="checkbox"/> Letter from employer/agency <input type="checkbox"/> Letter from employer/agency
<small>* 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.</small>	

3) PLEASE INDICATE THE CHANGE YOU WISH TO MAKE
The change must be consistent with your Qualifying Event and described on the FSA 2010 Enrollment/Change Form, which you must return with this form <u>within 30 days</u> after the Qualifying Event.
<input type="checkbox"/> Start account (Please complete an FSA 2010 Enrollment/Change Form) <input type="checkbox"/> 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), and that 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 2010 Enrollment/Change Form with this form and all documentation, within 30 days after the Qualifying Event, to:

Tax-Favored Benefits Program - FSA 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:									