

HEALTH CARE SPENDING ACCOUNT CHANGE IN STATUS FORM

CHECK ONE:

- NEW HIRE ENROLLMENT
 CHANGE IN STATUS

PLEASE CAREFULLY READ THE INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS FORM

PLEASE TYPE OR PRINT CLEARLY

EMPLOYEE NAME LAST		FIRST	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
HOME ADDRESS STREET			CITY		STATE ZIP CODE
WORK PHONE AREA CODE	NUMBER	EXT.	HOME PHONE AREA CODE	NUMBER	PAYROLL CYCLE (CHECK ONE) <input type="checkbox"/> ADMINISTRATION <input type="checkbox"/> INSTITUTION
DEPARTMENT ID (5-DIGIT AGENCY CODE)	AGENCY OR FACILITY NAME (Ex: DOT, Health Dept.) AND CITY				NEGOTIATING UNIT CODE

CHANGE / ENROLLMENT REQUESTED

- START NEW ACCOUNT: My Total Annual Contribution \$ _____
- CHANGE EXISTING ACCOUNT: Current Annual Contribution \$ _____ New Annual Contribution \$ _____

DATE OF QUALIFYING EVENT: _____

IMPORTANT

- I understand that by completing and signing this form, I authorize the State to deduct the Health Care Spending Account contributions in pre-tax dollars from my paycheck, which can only be used to reimburse me for eligible health care expenses incurred during my period of coverage.
 - I understand any amount remaining in my Health Care Spending Account not used during this Plan Year will be forfeited since it cannot be carried forward to the next Plan Year.
 - I understand that funds in my Health Care Spending Account cannot be used to reimburse expenses covered by the Dependent Care Advantage Account.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
 - I understand that the amount of salary contribution will continue in effect throughout the Plan Year, unless I terminate employment or file an approved Change in Status with the FSA Administrator within 60 calendar days of the qualifying event or 45 days before the end of the calendar year.
 - I understand and agree that my employer and Fringe Benefits Management Company, the FSA Administrator, will not incur any liability resulting from either my participation in the Health Care Spending Account or my failure to sign or accurately complete this change in status form.

EMPLOYEE SIGNATURE _____ DATE _____

GOER USE ONLY

Date Received	GOER Authorization	Period of Coverage	New Deduction Amount	First Deduction	No. of Remaining Paychecks	Pay Basis Code
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FBMC USE ONLY

Data Entry	Verification	Scanned	Indexed	Special Notes
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KEEP A COPY OF THIS FORM FOR YOUR RECORDS

NYS FLEX SPENDING ACCOUNT — HCSACCOUNT
A STATE EMPLOYEE BENEFIT THAT PUTS MONEY IN YOUR POCKET
www.flexspend.state.ny.us
1-800-358-7202

REV. 8/05

HEALTH CARE SPENDING ACCOUNT

CHANGE IN STATUS FORM INSTRUCTIONS

1. Complete the Health Care Spending Account worksheet available in the Flex Spending Account enrollment book or on the Flex Spending Account web site (www.flexspend.state.ny.us) before deciding how much you wish to contribute through tax-free salary deductions.
2. On the front of this form, indicate the **annual** election amount that you wish to contribute for your new period of coverage. The maximum allowable annual contribution is \$3,000 and the minimum allowable annual contribution is \$150. Your biweekly payroll deduction amount will be determined by the FSA Administrator based on the number of payrolls remaining in the Plan Year.
3. Please remember to sign your form – your application can't be processed without your signature. If you forget to sign your form, it will be returned to you.
4. If you are a **new State employee enrolling during the Plan Year**, check the “New Hire Enrollment” and “Start New Account” boxes, and include your employment start date (the first day you reported to work) on the line that says “Date of Qualifying Event”. Submit your completed form to: Governor’s Office of Employee Relations, Employee Benefits Management Unit, 2 Empire State Plaza Suite 1201, Albany, New York 12223. **Your form must be received within 60 calendar days of your employment start date in order to be approved.** You will be able to submit claims for health care services that are received *after* the completion of 60 consecutive calendar days of State service.
5. If you are **enrolling during the Plan Year due to a Change in Status**, check the “Change in Status” and “Start New Account” boxes, and include the date of your qualifying event on the front of this form. Submit your completed form and supporting documentation (example: marriage license, birth certificate, death certificate) to: Governor’s Office of Employee Relations, Employee Benefits Management Unit, 2 Empire State Plaza Suite 1201, Albany, New York 12223. **Your form must be received within 60 calendar days of your qualifying event in order to be approved.** Your health care expenses will be eligible for reimbursement if the date of service is on or after the date this form is received by the Governor’s Office of Employee Relations *or* after the date of your qualifying event, *whichever is later*.
6. If you are **changing your annual contribution due to a Change in Status**, check the “Change in Status” and “Change Existing Account” boxes, and include the date of your qualifying event on the front of this form. Submit your completed form and supporting documentation (example: marriage license, birth certificate, death certificate) to: Fringe Benefits Management Company, Attention CIS Department, P.O. Box 1878, Tallahassee, Florida 32302-1878. **Your form must be received within 60 calendar days of your qualifying event in order to be approved.** Your health care expenses will be eligible for reimbursement if the date of service is on or after the date this form is received by Fringe Benefits Management Company *or* after the date of your qualifying event, *whichever is later*.
7. If you have questions, consult your enrollment book or the Flex Spending Account web site (www.flexspend.state.ny.us), or call Fringe Benefits Management Company at **1-800-358-7202**. You can also e-mail your questions to fsa@goer.state.ny.us.