



**Flexible Spending Account Salary Reduction Agreement – Change Form**

This form is used to request a change in Health Care FSA or Dependent Care FSA. Return this completed, signed form to the University Benefits office within 30 days of a qualifying event (60 days for birth or adoption).

**Employee Information:**

Name: (L, M, F) \_\_\_\_\_ University ID: \_\_\_\_\_

**Requested Change:**

Health Care FSA:

Dependent Care FSA:

Current annual election amount: \_\_\_\_\_

Current annual election amount: \_\_\_\_\_

Requested annual election amount: \_\_\_\_\_

Requested annual election amount: \_\_\_\_\_

**Qualifying Event:**

The qualifying event must have direct impact on the FSA. Your request will be reviewed and a determination made as to whether the requested change is consistent with the event. You may be required to submit documentation to verify the event.

Qualifying Event: \_\_\_\_\_

Date of Event: \_\_\_\_\_

Individuals Affected by Event: \_\_\_\_\_

Describe the change you wish to make and any other relevant information that pertains to this request:

\_\_\_\_\_  
\_\_\_\_\_

I have read and understand the agreement. I certify that the above information is accurate and true and agree to provide any necessary documentation to verify the event. I understand that this agreement, once approved, is irrevocable and cannot be changed unless there is another qualifying event. I understand that this agreement will be subject to any changes or limitations mandated by Federal Law after the execution of the agreement.

I hereby authorize Iowa State University to make the above stated pre-tax deductions from my paycheck in accordance with my pay schedule.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_