



Election Change Request for Pre-Tax Benefit Accounts



The Wisconsin Department of Employee Trust Funds (ETF) offers an Open Enrollment period each year for pre-tax benefit accounts. After that time, you may make changes to your elections and enrollment using this form.

For Health Care and Dependent Day Care Flexible Spending Account (FSA) changes, you must have a qualified life change event, listed below, and your request must be received within 30 days of the qualified life change event. For Health Savings Account (HSA), Parking Account, and Transit Account changes, you are not required to have a qualifying life event in order to make an election change. The contribution change will be effective the 1st of the month following the application received date.

Note: ETF has adapted a limited expansion mid-year election change for the Health Care FSA, Limited Purpose FSA, and Dependent Day Care Account, which allows participants who have already enrolled in the benefit programs to make an election change effective July 1, 2020 through September 1, 2020 in response to COVID-19. Participants are allowed a one-time exception affected by COVID-19 (Step 3 below) to either increase or decrease their annual election. The decrease in annual election cannot be lower than what has already been paid out for claims reimbursement or contributed (whichever is greater).

Instructions:

- Employee: Complete this form and submit it to your Employer Benefits Specialist or Payroll Benefits Staff. Keep a copy for your personal records. NOTE: If changing your election prior to the start of the plan year (January 1), please use the Rescind Request Form.
- Employer: Update the employee's record in your HRIS/Payroll System. Retain a copy of the form for your records.

Employer Section:	Change Effective Date:	First Payroll Affected Date:
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STEP 1: Personal Information

First Name:	Last Name:
Employer Name:	Employee ID:

STEP 2: Election Changes

	Current Payroll Deduction Amount	New Payroll Deduction Amount	Revised Annual Election*
Health Savings Account	\$	\$	\$
Health Care Flexible Spending Account	\$	\$	\$
Limited Purpose Flexible Spending Account	\$	\$	\$
Dependent Day Care Account	\$	\$	\$
Transit Account	\$	\$	\$
Parking Account	\$	\$	\$

*Required to be entered. The revised annual election amount is determined by adding your year-to-date deductions (taken at the old rate) to your deductions to be taken for the remaining pay periods of the Plan Year.

STEP 3: Reason for Request - This section only required for Health Care, Limited Purpose and Dependent Care FSAs

<p>These changes apply to both Health Care, Limited Purpose and Dependent Day Care FSAs:</p> <p><input type="checkbox"/> Change in employment status</p> <p><input type="checkbox"/> Change in legal marital status</p> <p><input type="checkbox"/> Change in number of dependents</p> <p><input type="checkbox"/> COBRA</p> <p><input type="checkbox"/> Dependent satisfies or ceases to satisfy eligibility requirements</p> <p><input type="checkbox"/> Entitlement to Medicare/Medicaid</p> <p><input type="checkbox"/> FMLA</p> <p><input type="checkbox"/> Judgement, decree or order</p> <p><input type="checkbox"/> COVID-19</p> <p><input type="checkbox"/> Other _____</p>	<p>These changes only apply to Dependent Day Care FSAs only:</p> <p><input type="checkbox"/> Addition/elimination of benefit package</p> <p><input type="checkbox"/> Change in coverage of spouse/dependent under other employer's plan</p> <p><input type="checkbox"/> Change in residence</p> <p><input type="checkbox"/> Change in the cost of coverage</p> <p><input type="checkbox"/> HIPAA special enrollment rights</p> <p><input type="checkbox"/> Loss of group health coverage sponsored by governmental or educational institutions</p> <p><input type="checkbox"/> Significant curtailment of coverage</p> <p><input type="checkbox"/> Exchange Event: Reduction in hours (fewer than 30)</p> <p><input type="checkbox"/> Exchange Event: Exchange enrollment during Exchange open or special enrollment period</p>
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STEP 4: Authorization and Certification

I certify that the information on this form is accurate.

Account Holder Signature:	Date:
Employer Signature:	Date: