Flexible Spending Account (FSA) Change Form

King County
Benefits, Payroll and Retirement Operations

To request changes to your Health Care or Dependent Day Care FSA, complete, sign, and return within ***30 days of your qualifying life event*** to: Benefits, Payroll & Retirement Operations, Chinook Building CNK-ES-0230, 401 Fifth Ave., Seattle 98104-2333.

If you have questions, contact Benefits, Payroll and Retirement Operations at 206-684-1556 or kc.benefits@kingcounty.gov.

Name _____ PeopleSoft Employee ID _____

Email _____ Phone _____

Health Care FSA: Annual contribution change

A Health Care FSA account can be used to pay for eligible medical, dental, and vision care expenses for you, your spouse or eligible domestic partner, and your dependents—for example, deductibles, coinsurance, and copays. Up to $550 in unused funds in your Health Care FSA can rollover to the following plan year. Any other unused funds are forfeited. The minimum annual contribution is $300 and the maximum is $2,700.

Current Annual Contribution: $ _____ New Annual Contribution: $ _____

Dependent Day Care FSA: Annual contribution change

A Dependent Day Care FSA can be used to pay for day care or dependent care expenses for your child under age 13, disabled spouse, or dependent parent so you can work or attend school full-time. Unused funds cannot be refunded to you. The minimum annual contribution is $300 and the maximum is $5,000 per household or $2,500 if married, filling separately.

Current Annual Contribution: $ _____ New Annual Contribution: $ _____

Indicate the Qualifying Life Event

	Event Date
☐ Birth/adoption of a child (may be retroactive)	_____
☐ Change in dependent day care cost or coverage	_____
☐ Change in employment status ☐ Self ☐ Spouse	_____
☐ Change in legal marital status: ☐ Marriage ☐ Divorce ☐ Legal Separation	_____
☐ Death ☐ Spouse ☐ Child	_____
☐ Other. Please explain: _____	_____

Authorize your change

I have read and understand this form, including the information about qualifying life events. The information I have provided is true, correct and complete, and amends previously submitted information. I authorize King County to make any payroll deductions or refunds resulting from my requested change.

Employee signature_____ Date _____

Office Use Only	Received	Processed By	Pay Date Effective	FSA Change Effective Date
	Date: _____ Name: _____	Date: _____ Name: _____	_____	_____