IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

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:

Current annual election amount: _____

Requested annual election amount: _____

Dependent Care FSA:

Current 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: _____