

University of Michigan

Dependent Care Flexible Spending Account Request for Change in Status

For HRRIS BTT Use Only

Event Date _____

Input Elections _____

When you have a qualifying change in status, you may request a change in your election to revoke the existing plan election and make a new election for the remainder of the current plan year. Your requested election change has to have a direct impact on the Dependent Care Flexible Spending Account. Complete and submit this form to the HRRIS Benefits Transaction Team as instructed at the bottom of page 2 **within 30 days of the change in your status**. Your request will be reviewed and a determination made as to whether the request is in line and consistent with the event. Print all information in **black ink**. For a list of qualified family status change events that allow you to change your FSA election amount, please refer to the Benefits Office Web site at www.umich.edu/~benefits/plans/reimburse/effec-

1. Faculty or Staff Member Information.

Name (Last, First, Middle Initial)		UMID	Social Security Number (If UMID is unknown)
Street Address		City, State, Zip	Home Phone Number
Email Address	Does your spouse also work for the University of Michigan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, spouse's name and UMID:	Daytime Phone Number

2. Change of Status Event. You may be required to submit appropriate documentation to verify the event.

Date of Change of Status event identified below _____

Check one of the following qualifying changes in status events that you have experienced.

<input type="checkbox"/> Marriage	<input type="checkbox"/> Change in day care setting that <input type="checkbox"/> Costs less or <input type="checkbox"/> Costs more
<input type="checkbox"/> Divorce	<input type="checkbox"/> Day care provider <input type="checkbox"/> Decreases costs <input type="checkbox"/> Increases costs
<input type="checkbox"/> Birth of Child	(Note: Change in election amount cannot be made if due to cost increase when the day care provider is a relative of the employee)
<input type="checkbox"/> Adoption (or placement for adoption) of child	<input type="checkbox"/> Other (please specify below): _____
<input type="checkbox"/> Death of: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
<input type="checkbox"/> Change in employment/benefit eligibility <input type="checkbox"/> Self <input type="checkbox"/> Spouse	
<input type="checkbox"/> Ineligibility of dependent (due to age, custody or tax exemption status)	

3. Explanation of Requested Change. This section must be completed for all requests.

Please explain below the election change you wish to make and why your requested change is consistent with your status change. An election change is consistent only if the election change is necessary or appropriate as a result of the status change event.

4. Requested Annual Election Amount Change.

Current Annual Election Amount \$ _____

New Annual Election Amount \$ _____

5. Agreement and Confirmation.

I have read and fully understand the regulations to change my election. I understand that this Change in Status Form must be completed and returned to the Benefits Office within 30 days of the change in status event, and the election change I have requested must be consistent with the change in status event. I understand any election change will be effective the first of the month following the date this form is received in the Benefits Office, or the date of the change in status, whichever is later. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my period of coverage. Expenses incurred before the effective date of my change will not be reimbursed. I certify that the above information is true and correct, and agree to provide any necessary third-party documentation to verify the change in status event. I have read and understand the agreement and confirmation set out on the reverse side of this form concerning flexible spending accounts.

Signature of Faculty or Staff Member

Date Signed

Flexible Spending Account Request for Change in Status

Agreement and Confirmation

By my signature on the Flexible Spending Account Request for Change in Status Form, I confirm that I understand and agree to the following requirements of participation in a flexible spending account.

Contribution Amounts

1. There are minimum and maximum amounts that can be contributed to the Flexible Spending Accounts each year. For a health care account, the minimum annual contribution is \$120 and the maximum annual contribution is \$6,000. You may contribute from \$120 up to a possible maximum of \$5,000 per year to a Dependent Care FSA.

For faculty and staff who earned *less than* \$95,000 in 2005, the maximum annual contribution to a dependent care account is the lesser of \$5,000 family maximum or the earned gross income of the lower-paid spouse (if married), except when the spouse is disabled or a full-time student.

For faculty and staff who earned *more than* \$95,000 in 2005, the maximum annual contribution to a dependent care account is the lesser of \$300 per month or the earned gross income of the lower-paid spouse (if married), except when the spouse is disabled or a full-time student. See "Special Limits for Highly Compensated Faculty and Staff" for more information.

Deductions

2. Deductions will occur over 12 paychecks for faculty and staff members paid monthly, and over 24 paychecks for staff members paid bi-weekly. Deductions for mid-year enrollments will be based on the number of paychecks remaining in the calendar year after the effective date. Deductions cannot be taken from stipend or fellowship funds. No deductions will be taken during periods such as a leave when the enrollee is not receiving a salary from the University.
3. **Deductions cannot be changed or canceled during 2006 unless a qualified family status change occurs (marriage, divorce, birth of baby, etc.) in which event the coverage change must be consistent with the change in status.** If such a change occurs, the participant must provide documentation of the change to the Benefits Office **within 30 days** of the event. Otherwise, the change cannot be made until the next Open Enrollment period.
4. Changes in deduction amounts will be effective the first day of the month following the receipt of the authorization form or date of eligibility, whichever is later. For example, assume that you enroll in a Health Care FSA to begin on January 1 and designate an annual contribution amount of \$300. Then, on April 1 you increase the annual contribution amount to \$1,000 due to a family status change. Between January 1 and March 31, \$300 is available for incurred expenses. Any expenses incurred after April 1 are eligible for reimbursement up to \$1,000, assuming no claims were previously filed.

Claims

5. Eligible expenses incurred on or after the effective date of coverage through March 15, 2007 can be claimed for reimbursement. Duplicate reimbursement is not allowed. That is, expenses cannot be reimbursed by another source (such as a health insurance plan) or taken as an income tax deduction *and* reimbursed under a flexible spending account.
6. Be sure to sign your claim form. SHPS will not process a claim if the form does not include your signature.
7. A claim form for reimbursement from a Health Care Flexible Spending Account must be accompanied by an itemized receipt and an Explanation of Benefits (EOB) form. An EOB form is provided by the health insurance company after a claim is filed. HMOs do not

provide EOB forms. Participants who are enrolled in an HMO should submit an original itemized bill to document expenses. Participants enrolled in the BCBSM/United health plan should submit claims to both BCBSM and United of Omaha before submitting a claim form to the Health Care FSA.

8. For Health FSA expenses not covered by insurance, reimbursement requests will not be processed without acceptable evidence of your expenses. SHPS will not accept cancelled checks in lieu of a bill or receipt. Receipts must include the type of service, date expense was incurred, patient's name, name of the provider of service, and amount of expense. Statements showing only previous balances, or the amounts paid or balances due are not acceptable documentation.
9. You can fax your claims forms. SHPS has established a toll-free fax number, 1-877-270-3922, for the exclusive use of UM FSA participants. Keep a copy of the fax transmission report as documentation the fax was successfully transmitted and received by SHPS.
10. Keep a copy for your personal files for all documentation submitted to SHPS. Bills or receipts cannot be returned.
11. Flexible Spending Account claims **received** by SHPS, claims processor for the University's FSA accounts, will generally be reimbursed within 15 business days from the date SHPS receives your claim form. Dependent care reimbursements will not exceed the balance in the account as of the first of that month.
12. Funds cannot be transferred between the two types of accounts. Participation cannot be transferred to a spouse.
13. All eligible claims must be submitted to SHPS by the cutoff date, May 31, 2007. Any funds that remain in the accounts as of June 1, 2007 will be forfeited in accordance with IRS regulations. There are no exceptions to this rule. In accordance with IRS regulations, the University uses forfeited funds to pay administrative costs of the FSA program.

Special Limits for Highly Compensated Faculty and Staff

14. The IRS allows pre-tax contributions to an FSA as long as the plan does not favor highly compensated employees (HCE) as defined by the IRS. For 2006, you are considered "highly compensated" if you had gross earnings of \$95,000 or more in 2005. In accordance with IRS regulations against discrimination, the Benefits Office examines FSA plans each year to ensure that they do not disproportionately benefit employees the IRS considers "highly compensated." The Benefits Office determines the amount that can be contributed to a Dependent Care FSA by an HCE at the beginning of each year (\$3,600), but if at any time during the year that ratio is not being met, the University will reduce contributions made by participants who earn \$95,000 or more in 2005 to ensure compliance with IRS rules. If you are an HCE, your deduction may not exceed \$3,600 per family for a married couple filing jointly, or for a single parent. For an HCE married person filing separately the limit is \$2,500. If a Dependent Care FSA fails the nondiscrimination test, highly-compensated employees will be taxed on all of the dependent care assistance benefits they received during the calendar year. Employees who are not highly compensated are not affected by this rule.

General

15. This agreement expires no later than December 31, 2006. A new agreement is required each year.



Questions?

If you have any questions, view the Benefits Office Web site at www.umich.edu/~benefits, or call the HR/Payroll Service Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.).

How to Return Your Signed and Completed Form

By FAX

Fax it to 734-763-0363.
Keep a copy of the fax transmission report with your form in your records.

By Mail

Make a copy for your records and send the original by **Campus Mail** or **U.S. Mail** to:
HRRIS Benefits Transaction Team
4073 Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1281

Drop It Off In Person

Bring a photocopy of your completed form and ask the receptionist to stamp the copy "received" for your records.

U-M Ann Arbor
HR Service Center
Wolverine Tower – Low Rise G250
3003 South State Street
Ann Arbor, MI 48109-1278

U-M Flint
UHR – Flint
213 University Pavilion
303 East Kearsley Street
Flint, MI 48502-1950