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University of Michigan

Health Care Flexible Spending Account Request for Change in Status

The CARES Act for 2022 does not allow for changes in your annual election unless you have experienced a qualified change as outlined in box 2 of this form. Therefore, you should **ONLY** use this form if you have experienced a **CHANGE IN STATUS**.

Please note: the University of Michigan 2022 Health Care FSA election amounts are between \$120.00 and \$2,750.00.

University of Michigan
**Health Care Flexible Spending Account
 Request for Change in Status**

For BTT Use Only

Event Date _____
 Input Elections _____

When you have a qualifying family status change, 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 Health Care Flexible Spending Account. Complete and submit this form to SSC Benefits Transactions 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. For a list of qualified family status change events that allow you to change your FSA election amount, please refer to the University HR website at hr.umich.edu/fsa-changes. Print all information in **black ink**.

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 change in status events that you have experienced.

<input type="checkbox"/> Marriage	<input type="checkbox"/> Eligibility for Medicare and Medicaid
<input type="checkbox"/> Divorce	<input type="checkbox"/> Change in employment status that effects the eligibility of: <input type="checkbox"/> Spouse <input type="checkbox"/> Self
<input type="checkbox"/> Birth of Child	<input type="checkbox"/> Other (please specify below): _____
<input type="checkbox"/> Adoption (or placement for adoption) of child	_____
<input type="checkbox"/> Death of: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
<input type="checkbox"/> Ineligibility of dependent (due to age, custody or residence)	
<input type="checkbox"/> Judgement, decree, or court order	

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 HR-RIS Benefits Transaction Team 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 that any election change will be effective the first of the month following the date this form is received by the SSC Benefits Transaction Team, or the date of the change in status, whichever is later.** I understand that the change requested can only apply to the remaining portion of my period of coverage. 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 second page of this form concerning flexible spending accounts.

 Signature of Faculty or Staff Member

 Date Signed

Health Care 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 \$2,750.

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 the year 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 SSC Benefits Transactions **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 Flexible Spending Account Deduction Authorization Form or date of eligibility, whichever is later.

Claims

5. Eligible expenses incurred on or after the effective date of coverage through March 15 of the following year 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. PayFlex 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 generally do not provide EOB forms. Participants who are enrolled in an HMO should submit an original itemized bill to document expenses.

8. For Health Care FSA expenses not covered by insurance, reimbursement requests will not be processed without acceptable evidence of your expenses. PayFlex will not accept canceled 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. PayFlex has established a toll-free fax number, (855) 703-5305, for the exclusive use of U-M FSA participants. Keep a copy of the fax transmission report as documentation the fax was successfully transmitted and received by PayFlex.

10. Keep a copy of all documentation submitted to PayFlex. Bills or receipts cannot be returned.

11. Flexible Spending Account claims **received** by PayFlex, claims processor for the university's FSA accounts, will generally be reimbursed within 15 business days from the date PayFlex 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 Health Care and Dependent Care Flexible Spending Accounts. Participation cannot be transferred to a spouse.

13. All eligible claims must be submitted to PayFlex by the cutoff date, May 31 of the following year. Any funds that remain in the accounts as of June 1 following the plan year 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.

General

15. This agreement expires no later than December 31 of the plan year. A new agreement is required each year.



HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?

If you have any questions, visit hr.umich.edu/benefits-wellness, or call the SSC Contact Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.) Monday through Friday from 8 a.m. to 5 p.m.

How to Return Your Signed and Completed Form

Receipt Confirmation

A confirmation email will be sent to your UMICH email address within 72 hours of receipt of your 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:
SSC Benefits Transactions
Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1276