



Flexible Spending Accounts (FSA) Election Form

In the event of a qualifying status change, you may enroll or make changes to a Flexible Spending Accounts (FSA) election for the remainder of the plan year (eligibility date–December 31). In compliance with IRS regulations, when a qualifying status change occurs, **written notification must be received within 31 days of the status change**, and the change to an FSA election must be consistent with that status change. Complete the applicable section(s) below and attach documentation of the event, as appropriate.

To continue participation in an FSA after December 31, you **MUST** re-enroll annually during open enrollment.

SECTION I: PERSONAL INFORMATION (print or type)

Faculty/Staff Member's Full Name:

First M.I. Last OSU Employee ID Number

Home Mailing Address: Street City State Zip Code

E-mail Address Daytime Phone Number

SECTION II: REASON FOR COMPLETING FORM

Date of status change: _____ (return within 31 days)

- Hired/Newly Eligible
- Marriage
- Divorce¹
- Change in Dependent Eligibility¹
- Birth/Adoption/Legal Guardianship¹
- Change in spouse's employment status affecting eligibility for benefit¹
- Other: _____

¹Documentation may be required.

SECTION III: CONTRIBUTION LEVEL

HEALTH CARE SPENDING ACCOUNT

Used to reimburse health care expenses incurred for yourself and your qualifying dependents.

- Minimum election is \$100 for the plan year (eligibility date–December 31)
- Maximum election is \$5,000 for the plan year (eligibility date–December 31)

I wish to redirect the following pre-tax payroll funds into my Health Care FSA from my pay:

\$ _____ election for the entire plan year (eligibility date–December 31)

(Per pay election = above election amount ÷ number of pay periods remaining through December 31)

DEPENDENT CARE SPENDING ACCOUNT

Used to reimburse dependent care expenses incurred for your qualifying dependents (does not include dependent health care expenses). The maximum allowable calendar year contribution is \$5,000, per IRS regulations.

- Minimum election is \$250 for the plan year (eligibility date–December 31)
- Maximum election is \$5,000 for the plan year (eligibility date–December 31)

I wish to redirect the following pre-tax payroll funds into my Dependent Care FSA from my pay:

\$ _____ election for the entire plan year (eligibility date–December 31)

(Per pay election = above election amount ÷ number of pay periods remaining through December 31)

SECTION IV: AUTHORIZATION

I have received, read, and understand the material explaining the terms and conditions of The Ohio State University Flexible Benefits Plan. I understand that any person who, knowingly and with intent to defraud, files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year (eligibility date–December 31) unless a qualifying status change occurs, as defined by the plan. The Office of Human Resources must receive notification of such change within 31 days. I hereby authorize the pre-tax salary redirection for the plan year stated herein. I understand that any funds remaining in my Flexible Spending Accounts (FSA) at the close of the plan year may be forfeited as dictated by federal regulations. I understand that payroll contributions will begin with the first pay issued after the date this form is processed.

I certify that all information provided on this form is true and correct to the best of my knowledge.

Signature _____ Date _____

If you have questions, contact the Office of Human Resources Customer Service Center at service@hr.osu.edu, hr.osu.edu, (614) 292-1050, 1-800-678-6010.

Return completed form to: Office of Human Resources, Benefits Processing/FSA, 1590 N. High St., Suite 300, Columbus, OH 43201-2190

