PEEHIP FSA Change
(7/15)
2I

ACTIVE MEMBERS ONLY

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334.517.7000 or 877.517.0020; Fax: 334.517.7001 or 877.517.0021
Website: www.rsa-al.gov

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Email Address
_____/_____/_____	_____-_____-_____	_____-_____-_____	

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Reason for Status Change

I certify that I have incurred the following change in status:

- ☐ Marriage
- ☐ Marriage of dependent
- ☐ Birth of a child
- ☐ Adoption of a child
- ☐ Legal custody of a child
- ☐ Divorce/annulment
- ☐ Death of spouse/dependent
- ☐ Dependent loss of coverage
- ☐ Dependent no longer in daycare *(Dependent Care FSA only)*
- ☐ Significant change in medical benefits or premiums
- ☐ Termination of spouse/dependent employment
- ☐ Commencement of spouse/dependent employment
- ☐ Taking leave under the Family and Medical Leave Act
- ☐ Medicare/Medicaid entitlement
- ☐ Unpaid Leave of Absence
- ☐ Short plan year

Date qualifying event occurred ***(Required)*** _____/_____/_____

Note: *PEEHIP must be notified within 45 days of the occurrence of the qualifying event.*

Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____

Maximum amount cannot exceed $2,550 and the minimum annual amount is $120. New monthly contribution amount will be determined by dividing the remaining election amount by the total months remaining in this plan year.

☐ Stop Payroll Deductions

Reimbursement Option Change can only be made by calling BCBS Flex at 800.213.7930.

Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____

Maximum amount cannot exceed $5,000 if single or married filing a joint return, $2,500 if married filing separate returns. The minimum annual amount is $120. New monthly contribution amount will be determined by dividing the remaining election amount by the total months remaining in this plan year.

☐ Stop Payroll Deductions

PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature _____ Date Signed _____/_____/_____