



Los Angeles Unified School District Benefits Administration FLEXIBLE SPENDING ACCOUNT REQUEST FOR CHANGE

<i>Employee Number</i>	<i>Last Name</i>	<i>First Name</i>		<i>M.I.</i>
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Phone Number</i>
<i>Social Security Number</i>		<i>Do Not Write in Shaded Area</i>	<i>Eff.Date</i>	<i>Initials</i>
			<i>Date Processed</i>	

I declare that I have had a qualified major life event.

Effective Date of Change: _____

The changes in status are limited to the following events:

- Change in legal marital status including marriage, divorce, legal separation, annulment or death of spouse;
- Change in number of dependents including birth, adoption, placement for adoption and death of a dependent;
- Termination or commencement of employment by the employee, spouse, or a dependent;
- Change in employment status (for employee, spouse, or employee's dependent) that affects eligibility for health insurance benefits;
- A dependent satisfies or ceases to satisfy the plan requirements;
- A change in place of residence or work of the employee, spouse, or dependent that affects eligibility, such as moving into or out of an HMO's service area.

Note: An election change must be consistent with the change in status. Please submit this form along with proof of your major life event within 30 days of the event.

I hereby request a change in the deduction from my pre-tax salary, per pay period. **(Note: Changes will be made on future deductions only)**

Part I – Health Care Flexible Spending Account

Part II – Dependent Care Flexible Spending Account

From: \$ _____ annual amount

From: \$ _____ annual amount

To: \$ _____ annual amount

To: \$ _____ annual amount

*The number of deductions is 12 for employees on a monthly pay schedule and 24 for employees on a semi-monthly pay schedule.

I have read the above, and under penalty of perjury, I declare the statement is true, accurate, and complete to the best of my knowledge.

I understand that the Flexible Spending Account deduction(s) will be in effect for the plan year and cannot be revoked unless I experience another qualified major life event.

Employee's Signature _____ **Date** _____

Return the completed change form (fax or email preferred) to:

Fax: (213) 241-4247
Email: benefits@lausd.net

Los Angeles Unified School District
Benefits Administration, Flexible Spending Account
P.O. Box 513307
Los Angeles, CA 90051-1307