PEEHIP FSA Change
(08/12)
2I

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

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:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000 and the minimum annual amount is $120.

☐ 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:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual 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.

☐ 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 _____/_____/_____