



# Do you need to change your dependent care FSA deduction?



## Dependent care deduction changes can be made with a qualifying life event, including:

- Adoption
- Birth
- Cost change (increase or decrease)
- Daycare provider change
- Death
- Divorce
- Employment change (for the employee or employee's spouse)
- Legal separation
- Marriage
- No longer a dependent

## Process:

Complete the Change of Status form included below.

Submit the completed form to [BenefitsHelp@aruplab.com](mailto:BenefitsHelp@aruplab.com).

Questions? Email [BenefitsHelp@aruplab.com](mailto:BenefitsHelp@aruplab.com) or call ext. 2282.

# Cafeteria Plan Change of Status Form

Please complete this form and email it to: [benefitshelp@aruplab.com](mailto:benefitshelp@aruplab.com)



## 1 Personal Information

Employee Name

ARUP Laboratories, Inc.

Company Name

Street Address, City, State, Zip

Current Date

Date of Event/Termination

Social Security Number

## 2 Qualifying Event

- Change of Status - List all dependents (including Spouse): i.e. Marriage, Divorce, Death, Legal Separation, Birth, Adoption, No Longer Dependent, Employment Change, Spousal Employment Change, etc.

| Full Name | Date of Birth | Relationship | Reason for Change of Status |
|-----------|---------------|--------------|-----------------------------|
| _____     | _____         | _____        | _____                       |
| _____     | _____         | _____        | _____                       |
| _____     | _____         | _____        | _____                       |
| _____     | _____         | _____        | _____                       |
| _____     | _____         | _____        | _____                       |

- Change Cost or Provider – Dependent Care i.e. Change of Day Care Provider, Cost Increases or Decreases

- Termination of Employment

## 3 Change of Benefit

The payday that the new deduction begins: \_\_\_\_\_

Date of last payroll deduction (if termination of employment): \_\_\_\_\_

|                     | Prior Annual Election Amount | New Annual Election Amount | Frequency of Withholding (weekly, semi-monthly, etc.) |
|---------------------|------------------------------|----------------------------|---|
| Health Care Expense | _____                        | _____                      | _____   |
| Day Care Expense    | _____                        | _____                      | _____   |

## 4 Employee Signature/Company Representative Signature

Employee Signature

Date

Company Representative Signature

Date