



Election Change Request for Pre-Tax Benefit Accounts



The Wisconsin Department of Employee Trust Funds offers an Open Enrollment period each year for pre-tax benefit accounts. After that time, you may make changes to your elections and enrollment in these accounts if you have a qualified life change event, listed below.

Deadline: Your request must be received within 30 days of the qualified life change event.

Instructions:

- Employee: Complete this form and submit it to your Employer Benefits Specialist or Payroll Benefits Staff. Keep a copy for your personal records. NOTE: If changing your election prior to the start of the plan year (January 1), please use the Rescind Request Form.
- Employer: Update the employee's record in your HRIS/Payroll System. Retain a copy of the form for your records.

Employer Section	
Change Effective Date:	First Payroll Affected Date:

STEP 1: Personal Information

First Name:	Last Name:
Employer Name:	Employee ID:

STEP 2: Election Changes

	Current Payroll Deduction Amount	New Payroll Deduction Amount	Total Annual Deduction Amount**
Health Savings Account	\$	\$	\$
Health Care Flexible Spending Account	\$	\$	\$
Limited Purpose Flexible Spending Account	\$	\$	\$
Dependent Day Care Account	\$	\$	\$
Transit Account*	\$	\$	\$
Parking Account*	\$	\$	\$

*UW System and UW Hospitals & Clinics employees are not eligible for Transit or Parking Benefits.
 **Required field. Add up your year-to-date elections at current rate, then add your remaining elections for the year at the new rate.

STEP 3: Reason for Request

<input type="checkbox"/> Change in employment status <input type="checkbox"/> Change in legal marital status <input type="checkbox"/> Change in number of dependents <input type="checkbox"/> COBRA <input type="checkbox"/> Dependent satisfies or ceases to satisfy eligibility requirements <input type="checkbox"/> Entitlement to Medicare/Medicaid <input type="checkbox"/> FMLA <input type="checkbox"/> Judgement, decree or order	These reasons do not apply to Health Care Flexible Spending Accounts: <input type="checkbox"/> Addition/elimination of benefit package <input type="checkbox"/> Change in coverage of spouse/dependent under other employer's plan <input type="checkbox"/> Change in residence <input type="checkbox"/> Change in the cost of coverage <input type="checkbox"/> HIPAA special enrollment rights <input type="checkbox"/> Loss of group health coverage sponsored by governmental or educational institutions <input type="checkbox"/> Significant curtailment of coverage <input type="checkbox"/> Exchange Event: Reduction in hours (fewer than 30) <input type="checkbox"/> Exchange Event: Exchange enrollment during Exchange open or special enrollment period
---	--

STEP 4: Authorization and Certification

I certify that the information on this form is accurate.

Account Holder Signature:	Date:
Employer Signature:	Date: