SF 4400-CFB (11-2008) Supersedes (6-2008) Issue

UCI (when completed)

Flexible Spending Account
Mid-Year Election Change Request

NOTE: This form must be RECEIVED in the Benefits Department within 31 calendar days of the mid-year election change event in order to enroll or make a change in, or cancel, one or both Accounts.

Name: _____ SNL ID: _____

Home Address: _____

(Include city, state, zip code)

Sandia Organization: _____ Sandia Mail Stop: _____ Sandia Phone #: _____

Mid-Year Election Change Event: _____ Date of Event: _____

Reason for Change (explain why requested change is consistent with and on account of mid-year event):

Important: Refer to the Flexible Spending Accounts Summary Plan Description http://www.sandia.gov/benefits/spd/rsa/ for definition and applicable criteria regarding mid-year election change events. The change must be consistent with and on account of the mid-year election change event. The change will be effective on the later of the date of the mid-year election change event or the date the Benefits Department receives the completed paperwork. Note that pre-change expenses cannot be reimbursed from post-change coverage.

I wish to enroll in, disenroll from, or change the following Flexible Spending Account(s):

☐ **Health Care Flexible Spending Account** **New Annual Amount* $** _____

☐ **Day Care Flexible Spending Account** **New Annual Amount* $** _____

I would like the above change(s) to be effective beginning in calendar year (insert year): _____

* Enter the total new annual amount you desire for the calendar year in which you want this change to be effective. If you are making elections for multiple years, use a separate form for each year. For the Day Care Account, if you want to terminate your Account, write in the word "terminate." If the amount is not evenly divisible by the remaining pay periods, it will be rounded to the closest amount to be evenly divisible.

By signing below, I am indicating that the above mid-year election change event did in fact occur on the date indicated and that I wish to make the above change(s) requested.

Employee Signature: _____ Date: _____

If you have any questions, please call Health, Benefits & Employee Services, (505) 844-4237, Fax: (505) 844-7535.
Mail to MS-1463, Benefits Department.

For Benefits Department personnel only	
Received by:	Date:
Enrollment/Change Accepted:	Date:
Enrollment/Change Declined:	Date:

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