



2021 Midyear Flexible Spending Account Change Form

Indicate your changes below. The completed form will need to be printed and submitted to the Benefits Team for processing. Your election will be effective with your next paycheck, as long as the form is returned to the Benefits Team two weeks prior to payroll close. Please review to the [FAQs on the Human Resources website](#) for more information.

Name: _____ Employee ID#: _____

Healthcare Flexible Spending Account (HFSA)

_____ I wish to enroll in or increase my 2021 HFSA election to \$_____. I understand that if I am enrolling for the first time this year, I cannot be reimbursed for claims incurred prior to my enrollment date.

_____ I wish to decrease my 2021 HFSA election to \$_____. I understand that I cannot decrease my election to less than what I have already been reimbursed or contributed, whichever is higher.

_____ I wish to suspend future contributions to my 2021 HFSA election. I understand that if I have already been reimbursed more than I have contributed, my election will be changed to the amount I have been reimbursed, and I will continue to see deductions for the remainder of the year to total the amount of my reimbursements.

Dependent Care Flexible Spending Account (DFSA)

_____ I wish to enroll in or increase my 2021 DFSA election to \$_____. I understand that if I am enrolling for the first time this year, I cannot be reimbursed for claims incurred prior to my enrollment date.

_____ I wish to decrease my 2021 DFSA election to \$_____. I understand that I cannot decrease my election to less than what I have already contributed.

_____ I wish to suspend future contributions to my 2021 DFSA election.

By signing below, I am confirming my FSA election change. I understand and agree to the following: my salary will be reduced by the required employee contributions, if applicable. I understand that I may revoke this election only as permitted by the terms of the plan. I understand that if my FSA account(s) terminate(s) for any reason, I will only be able to submit for expenses incurred before the termination date.

Signature _____ Date _____

*Princeton University
Office of Human Resources
(609) 258-3302
benefits@princeton.edu*