Flexible Spending Account COVID-19 Related Changes Form
HR-DEFCOMP-052A

FOR COVID-19 RELATED CHANGES ONLY
Please email the completed form to the MTA Business Service Center at bscservice@mtabsc.org or via fax to 212-852-8700.

Employer Name: **MTA**	Plan Year: **2020**	☐ Male ☐ Female	BSC ID#
Employee Last name:		First Name:	M.I.:
Phone Number:		Date of Birth:	
E-mailAddress:			

Account Type		Election Amount		
Medical Expense Reimbursement	________	Current Annual Election	________	New Annual Election
Dependent Care Assistance	________	Current Annual Election	________	New Annual Election

☐ Cancel My Medical Expense Account Now

☐ Cancel My Dependent Care Account Now

Please Note:

If you choose to cancel your FSA election, you will still have until March 15, 2021 to incur eligible expenses for reimbursement from the balance in your P&A account.

PLEASE NOTE: The IRS recently issued changes that affect Flexible Spending Account (FSA) elections

Due to the impact of COVID-19, participants may change their Health Care FSA and Dependent Care FSA elections for the rest of the 2020 plan year without needing to provide a reason to do so. Options include revoking an election so that no further salary reduction contributions will be required, changing the annual election amount and making a new election when none was made during open enrollment.

The IRS relief does not allow for any refunds to participants who have been participating in Health Care FSA or Dependent Care FSA this year. If you choose to cancel your FSA election, you will still have until March 15, 2021 to incur eligible expenses for reimbursement from the balance in your P&A account. Please contact P&A to determine your account balance.

AUTHORIZATION
I hereby elect the benefits indicated above. I have read and understood the enrollment materials (FSA brochure, enrollment form) and I authorize my employer to adjust my pay as required by my election. I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT: **DATE:** / /