CHANGE OF OE 2025 FSA ELECTION
Valid November 1 to November 30, 2024
State of Connecticut

Participant Instructions: Complete and submit this form to osc.ebu@ct.gov or Fax to 860-702-3556.
Must be received by November 30 – No exceptions
Retain a copy and proof of transmission for your records

EMPLOYER INFORMATION

Client/Company Name:	**State Of Connecticut**	TASC ID #:	**4721-0392-1958**

PARTICIPANT INFORMATION

All fields are required for account setup unless otherwise indicated. Information is confidential and is not used for marketing purposes.

First Name:		MI:		Last Name:	
EMPLOYEE ID or TASC ID #:		Email Address: *			
Primary Phone #:		Mobile Phone #: *			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	

** Please provide this information if available (not required).*

INSTRUCTIONS

All changes of election require the change request to:

1. Have been elected during the Open Enrollment Period of October 1 to October 31, 2024, and
2. This change completed during November 1 to November 30, 2024, and
3. This change will supersede the election(s) originally made in the TASC system
4. Upon completing and signing the form, submit to osc.ebu@ct.gov or Fax to 860-702-3556 by November 30, 2024

ELECTION CHANGE(S)

I hereby request a change in my benefit election(s) as follows:		Revised Annual Election Amount		Minimum Employee Annual Election		Maximum Employee Annual Election	
☐	**Healthcare FSA**	$		$	**520**	$	**3,300**
☐	**Dependent Care FSA (DCAP)** – *Daycare Expenses*	$		$	**520**	$	**5,000**
			Revised Monthly Election				
☐	**Transit Account**			$	**20**	$	**325**
☐	**Parking Account**			$	**20**	$	**325**

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Sign the next page and submit all pages to osc.ebu@ct.gov
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AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Participant Signature: _____ **Date:** _____

Participant Name: _____
(Please Print)

For enrollment assistance email osc.ebu@ct.gov

Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits