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**Healthcare Flexible Spending Care (FSA) Mid-Plan Year Election Form**

|  |  |
| --- | --- |
| **Name:** |  |
|  |  |  |  |
| Due to the impact from COVID-19 related reasons, effective April 1, 2020, I elect to change my annual contribution amount to: |  |
|  |  |  |  |
| **Signature:** |  | **Date:** |  |