



## Paychex Benefit Account – Plan Amendment Request Form

Company Name \_\_\_\_\_

Federal ID \_\_\_\_\_ Office/Client Number \_\_\_\_\_

### Medical FSA Expense Reimbursement Maximum

Paychex is requested to change my company's annual plan maximum reimbursement level for unreimbursed medical/dental/vision contributions from \$ \_\_\_\_\_ to \$ \_\_\_\_\_. Therefore, employees shall be limited to, but may elect less than, \$ \_\_\_\_\_ per month for their FSA unreimbursed medical contributions. This will be effective January 1, \_\_\_\_\_.

### Medical FSA Annual Carryover Limit and Grace Period Option

Paychex is requested to make the following change to my company's annual carryover limit for plan year \_\_\_\_\_:

*Note: If the carryover option is chosen, the Grace Period option is not available.*

Add \$ \_\_\_\_\_ (up to \$660)      Change \$ \_\_\_\_\_ (up to \$660)      Remove

Paychex is requested to make the following change to my company's Grace Period option for plan year \_\_\_\_\_:

*Note: If the Medical FSA Grace Period option is chosen, the Carryover option is not available.*

Medical FSA Grace Period      Add      Remove

Dependent Care Assistance Grace Period      Add      Remove

### Employment Eligibility Requirement

Paychex is requested to change my company's employment eligibility requirement for unreimbursed medical/dental/vision contributions and dependent care assistance from \_\_\_\_\_ days of employment to \_\_\_\_\_ days of employment. This will be effective January 1, \_\_\_\_\_.

The following employees are excluded from eligibility for unreimbursed medical/dental/vision contributions and dependent care assistance:

Seasonal employees working less than \_\_\_\_\_ months per year

Part-time employees working less than \_\_\_\_\_ hours per week

Employees under the age of \_\_\_\_\_

Employees with a gross income between \$ \_\_\_\_\_ and \$ \_\_\_\_\_

Union employees

Non-resident aliens

Others \_\_\_\_\_

***I acknowledge that the medical FSA plan requirements and the employment eligibility requirements may only be changed prior to a new plan year, beginning January 1 of the following year. I acknowledge that the new plan contribution and/or employment eligibility requirement shall stay in effect for every plan year until the time that Paychex is notified to change the requirement.***

\_\_\_\_\_  
Authorized Company Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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