REQUEST TO CANCEL OR CHANGE
MED FSA / DCAP ACCOUNT

Printed Name: _____

Munis ID: _____

Effective Date: _____

I am requesting to cancel / change (circle/mark one) my participation in the:

____ Medical Flexible Spending Account

_____New annual election amount

____ Dependent Care Spending Account

_____New annual election amount

By my signature below, I acknowledge that I am eligible to make such cancellation or change due to my change of status (per IRS guidelines) for the reason indicated below (please check one):

____ Legal marital status

____ Number of dependents

____ Employment status

____ Change in dependent's satisfaction of eligibility requirements

____ Residency

____ Other _____

_____ _____

Signature Date

*Please return completed form to the Benefits Office.

For Office Use Only:

Date received in Benefits Office_____

Date of notification to Pinnacle_____

Date changed in MUNIS_____