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Flexible Spending Account 2019-2020

Election/Change Form for **APT, Faculty & Staff** FSA Plans

Employee Name _____
(Please Print) Last First SSN

Home Address _____ ___/___/___
Street City State Zip Birthdate

Home Phone_____ Work Phone _____ College/Agency _____

PURPOSE: This agreement is designed to allow an employee to convert a portion of his/her taxable earnings to a tax-free benefit status, pursuant to a Code Section 125 plan and other codes listed under a Flexible Benefit Plan.

AGREEMENT: The employer and employee mutually agree to this election. It is a binding agreement effective July 1, 2019 through June 30, 2020. No election changes are allowed unless an eligible status change or approved Family and Medical Leave Act change occurs. The election change must be requested within 31 days of the event and be consistent with the status change that occurred.

LIMITATIONS: Termination of employment with this employer terminates this agreement. Only expenses not reimbursed to the employee by any other insurance plan or company plan may be considered qualified expenses under the Flexible Benefit Plan.

I elect to reduce my gross wage and redirect the following dollars into the appropriate spending account(s) below:

Health Care **Spending** Account: $_____per pay period x _____# of pay periods = $ _____per plan year
(Minimum contribution is $25 per month; maximum contribution is $225 per month or $2,700.00 annually.)

Dependent Care **Spending** Account: $_____per pay period x _____# of pay periods = $_____per plan year
(Min. contribution is $25/month; max. contribution is $416.66/month or $5,000.00 annually.) See page 2.

List all dependents covered under the elected account. (Must be completed)

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		

I understand the benefit options available to me and choose the election(s) above. I understand that I will forfeit to the SBCCOE Trust any remaining dollars in excess of $500 if I do not incur eligible expenses by June 30, 2020 and submit my claims for reimbursement by September 30, 2020. I also understand that my future PERA benefits may be reduced by my participation in this plan and that all dollars elected through this plan cannot be applied as a deduction or credit on my tax return.

Employee Signature: _____ Date: _____

Dependent Care Questionnaire

Complete this questionnaire if you plan to use the dependent care spending account.

1. Does the dependent live in your home at least 8 hours each day? _____Yes _____No
   (If yes, expenses are eligible for this plan.)

2. Is your spouse unemployed and disabled? _____Yes _____No

3. Is your spouse a full-time student 5 months or more a year? _____Yes _____No
   (If yes to either #2 or #3, eligible expenses are limited to a maximum of $3,000 per year for one dependent or $5,000 per year for two or more dependents.)

I understand I cannot pay my spouse or other dependent for the care of my dependents, and my reimbursed expenses are limited to the income of the lesser earning spouse. The maximum plan year amount is $5,000 per family per year; $2,500 per individual spouse if married filing separate tax returns.

Employee Signature: _____ Date: _____

For HR Use Only

Reason for Election: (Circle One) New Hire Open Enrollment Status Change

Eligibility Date: _____ First Payroll Deduction Date: _____

Verified by: _____ Date: _____