#S________________

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 my Health Care Spending Account 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 understand my Dependent Care Spending Account balance cannot be rolled forward and any balance after June 30 will be forfeited. 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: ______________________________

<u>For HR Use Only</u>

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

Eligibility Date: ______________________________ First Payroll Deduction Date: ______________________________

Verified by: ______________________________ Date: ______________________________