Flexible Spending Accounts
ENROLLMENT FORM

County of Tehama _____ _____
Employer Name Department

_____ _____
Employee Name (Last, First, MI) SSN

_____
Employee Street Address City State Zip Code

_____ _____ _____
Home Phone Number Work Phone Number Date of Birth

Payroll type (Choose one): ___S_____
W=weekly, B=Bi-weekly, S=Semi-monthly, M=Monthly

_____I am a new hire. My hire date is _____
_____I am enrolling during open enrollment for the following calendar year.
_____I am making a change due to a status change effective _____.
My status change is_____
(Please provide proof of status change.)

I hereby agree that my cash compensation (salary) will be reduced by the amounts set forth below for each pay period during the current Plan Year (or during such portion of the year as remains after the date of this agreement). Such reductions, considered as Elective Contributions under the plan, shall commence with my paycheck dated _____ / _____ / _____.

FSA BENEFIT ELECTIONS:

	Pre Tax Deduction (**amount <u>per pay period</u>**)	**Total Plan Year Deductions** (**annual amount**) **(pay period amount X 24)**)
Medical Care Reimbursement Account: **($2,500 per year maximum)**	$_____	$_____
Dependent Care Assistance Account: **($5,000 per year maximum)**	$_____	$_____

<u>The amount you designate for deduction will remain in effect for the current plan year only. You must re-enroll each year for FSA deductions.</u>

This election form will remain in effect and cannot be revoked or changed during this Plan Year, unless the revocation and new election are due to and consistent with a Change in Family Status. (Examples: marriage, divorce, birth, death, adoption, or applicable employment changes of a spouse or employee)

AUTHORIZATION: I certify the above information to be correct and true and any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and/or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during this Plan Year will be forfeited in accordance with current Plan provisions and tax laws. I hereby authorize the deduction of the administrative fee, if applicable. I further certify that I have read the "Other Terms and Conditions" that are printed on the reverse side of this election form and understand the information provided herein.

Authorizing Signature _____ Date_____

- *DECLINING PARTICIPATION – The benefits of the Plan have been thoroughly explained to me and I decline to participate.*
- *Declining Signature* _____ *Date*_____

<u>Send this form to the Auditor's Office for processing.</u>

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke any of my elections, of this compensation reduction agreement, at any time during the plan year, unless I have a change in family status. Eligible changes in family status include marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of my spouse, change in my spouse's or my employment status from full-time to part-time or from part-time to full-time, my spouse or myself taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer sponsored health coverage, or such other events as the Plan Administrator determines will permit a change or revocation of an election.

- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me or used to provide benefits specifically for me in a later plan year.

- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected not to participate for the following plan year with the exception of the pre-taxing of my insurance premiums.

You cannot obtain reimbursement for:

1. The basic cost of Medicare Insurance (Medicare A).
2. Life Insurance or income protection policies.
3. Accident or health insurance for you or members of your family.
4. The hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax.
5. Nursing care for a healthy baby.
6. Illegal operations or drugs.
7. Travel your doctor told you to take for rest or change.
8. Cosmetic surgery.
9. Over the counter medications unless prescribed by a physician.

Qualifying medical expenses include only those expenses incurred for:

1. Yourself.
2. Your spouse.
3. All dependents you list on your federal tax return.
4. Any person that you could have listed as a dependent on your return if that person had not received $2,050 or more of gross income or had not filed a joint return. This amount is adjusted each year for cost of living.

IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that can be deducted and therefore reimbursed under this plan, and those that cannot.