BPC

Flexible Spending Accounts Enrollment Form

Champaign County: Plan Year January 1 – December 31, 20____

EMPLOYEE INFORMATION

Full Name: _____ SS # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Date of Birth: _____

❑ **Please check box if you have had an address change since last plan year.**

ENROLLMENT TYPE

❑ Open Enrollment

❑ Qualifying Event/Status Change (please include a completed Status Change Form)

Complete only if eligibility is ***AFTER*** Jan 1 Open Enrollment period:

❑ New Hire

Eligibility Date _____ First Payroll Date _____

PAYROLL FREQUENCY

❑ Bi-Weekly (24)

ELECTION AMOUNT

By my signature below, I authorize my Employer to make salary reduction contributions on my behalf to the following Flexible Spending Account(s) for the Plan year:

	Per Pay Period	*Annual Election*	
Dependent Care Account (DCA) $5,000 max per family or $2,500 per spouse when married and filing separate tax returns (per IRS)	$_____	$_____	❑ Decline Coverage
Health Flexible Spending (FSA) $2,500/yr maximum	$_____	$_____	❑ Decline Coverage

TERMS AND CONDITIONS

PLEASE READ CAREFULLY: I understand that ***premiums for applicable group health, dental, vision, or group term life, etc. will automatically be deducted on a pre-tax basis unless I sign the attached separate waiver form. A separate enrollment form must be completed for each insurance benefit.***

- I have received the Summary Plan Description (SPD). It is my responsibility to read and refer to the SPD for complete rules, regulations and restrictions and seek out my benefits administrator and/or BPC for questions or clarifications.
- I will not be permitted to change this election until the Annual Election Period except for the following changes in circumstances: marriage; divorce; death of spouse or child; increase or decrease in number of dependents; employment or termination of employment of spouse; change in employment status or location of employee; significant change in health insurance premium. I further understand that any change requested must be consistent with the change in circumstances that lead to such request.
- The Salary Reduction Contribution amounts elected above for any one Flexible Spending Account cannot be transferred to another Flexible Spending account and that any amounts remaining in my account(s) after the run-out period and any applicable roll-over or grace period, will be forfeited.
- If I should terminate employment I will be eligible to submit claims for health and child/dependent care reimbursement until the earlier of 1) the date the Flexible Spending Account balance is $0 or 2) the last day of the claim filing period. Health claims must be incurred prior to date of termination.
- I certify that all expenses for which I will request reimbursement of under these reimbursement accounts are valid expenses under the Plan and the Internal Revenue Code. I also certify that they are not reimbursable under another plan or source and may not be claimed on any federal income tax deduction or credit. If I have inadvertently received payment for an ineligible expense, I agree to provide repayment to the plan.
- I acknowledge that my participation in the Health Flexible Spending Account, except for certain limited-purpose Health FSA's, may disqualify myself and/or my spouse from opening or contributing to a Health Savings Account (HSA) for the duration of the FSA plan year.
- I understand that generally a Qualifying Individual for **Dependent Care Expenses** must share my same principal abode for more than half the year. Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the **custodial** parent even when the noncustodial parent is entitled to claim the dependency exemption for the child.

_____ _____

Signature of Employee Date

PLEASE RETURN TO DEBBIE HEISER, ADMINISTRATIVE SERVICES

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