Enrollment Form – Flexible Spending Accounts

July 1, 2020 – June 30, 2021

GENERAL INFORMATION:

Employee Number: ________________ Social Security Number: XXX-XX _ _ _ _

Employee Name:____

Mailing Address: ____

City:____________________________ State:______________ Zip: _______________________

Date of Birth: _____________________ Date of Hire: _______________________

FLEXIBLE SPENDING ACCOUNTS:

☐ I hereby elect to participate in the Flexible Spending Accounts **July 1, 2020 – June 30, 2021**

Please mark your selection by the amount you would like deducted PER PAY

Health Care FSA ($2,500.00 limit) $______________ per pay

Dependent Care FSA ($5,000.00 limit) $____________ per pay

(Day care expenses incurred during employment hours)

MY PAY SCHEDULE IS:

☐ City/G&E bi-weekly (26) ☐ School bi-weekly (26)

☐ Athenaeum ☐ School bi-weekly (22) Aides/Food Service

Effective date of Coverage: **July 1, 2020 – June 30, 2021**

Deductions will begin the first payroll in July 2020. Expenses must be incurred between July 1, 2020 and June 30, 2021

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

The $39.00 per year non-refundable Administrative Fee will be a separate deduction taken from my first pay.

____ _______________

Employee Signature Date

WageWorks is the administrator of your Plan.
Please return this form to your Employer.