Flexible Spending Account

Election/Change Form for SBCCOE Employee Benefit Plan

Employee Name _____
Last (print) First Initial SS #

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, 2011 through June 30, 2012. 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 and required by 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:

a. health care expenses $ _____ per pay period x _____ # pay periods = $ _____ per plan year

b. dependent care* $ _____ per pay period x _____ # pay periods = $ _____ per plan year

List all dependents and spouse/domestic partner (must be completed)

	Name	Date of Birth	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

I understand the benefit options available to me and choose the election(s) above. I understand that I forfeit all remaining dollars to the SBCCOE Trust if I do not incur eligible expenses while active in the plan and submit my claims for reimbursement by September 30, 2012. 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's Signature _____ Date ___/___/___

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

Dependent Care Questionnaire

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/domestic partner unemployed and disabled?	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.
3)	Is your spouse/domestic partner a full-time student 5 months or more a year?	Yes ☐	No ☐	

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

For Internal Use Only – New Elections During Plan Year

Reason for Election: ☐ New Hire ☐ Open Enrollment ☐ Status Change ☐ Termination

Eligibility date: _____ First payroll deduction date _____

Approved by: _____ Date: _____

White – Human Resources Canary – Employee

Revised (4/11)