Flexible Spending Accounts
ENROLLMENT FORM

City of Huntington Beach
Employer Name

Effective Date of Participation

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): Bi-Weekly

W=weekly, B=Bi-weekly, S=Semi-monthly, M=Monthly

Number of payroll deductions remaining: _____

(If enrolling mid-year, how many payroll periods remain.)

I hereby agree that my cash compensation (salary) will be reduced by the amounts set forth below for each pay period during the 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_____/_____/_____.

BENEFIT ELECTIONS

	Pre Tax Deduction (per deduction period)	Total Plan Year Deductions (annualized amount)
Medical Care Reimbursement Account:	$_____	$_____
Dependent Care Assistance Accounts:	$_____	$_____
TOTALS:	**$_____**	**$_____**

PLEASE NOTE – effective 1/1/2011 over-the-counter drug and medicine expenses are no longer eligible under the Medical Care Reimbursement Account unless accompanied by a prescription or letter of medical necessity from your provider.

2020 FSA Annual Contribution Limits:
Medical Care Reimbursement Account = $2,700
Dependent Care Assistance Account = $5,000

Premium Accounts: If you have elected coverage for an Employer sponsored health, dental, or vision plan, and you have authorized a payroll deduction to cover your cost for the coverage, that amount will be automatically pre-taxed. You will not be required to sign a form for your premium to be pre-taxed in this program.

Insured Benefit Plans: I understand that the selection of a benefit (voluntary benefits included) and the indication that a premium is to be paid does not include me in the insurance portions of this program (if applicable). An application for insurance must also be completed and in some cases approved by carrier.

This election form will remain in effect and cannot be revoked or changed during the 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 of 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 the Employee copy 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.*

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, change in my or my spouse's employment status, my spouse or I 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.

- If I select to be covered under disability insurance through the Plan, then any benefits paid to me from such insurance will be fully taxable to me and it will be my responsibility to include these amounts in my gross income.

- 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.

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 drug and medicine expenses that are not accompanied by a prescription or letter of medical necessity.**

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 $3,500 or more of gross income or had not filed a joint return. This amount is adjusted each year for cost of living.