TOOELE CITY
2018-2019 Flexible Spending Account Enrollment/Change Form

Name: _____ SSN: _____ Position: _____

Mailing Address _____
Street City State Zip Code

Phone: _____ Mobile: _____ Email: _____

ADDITIONAL FLEX CARDS (Flex Cards do not expire for three years. Please do not throw away. $10 replacement fee charged.**)**
List spouse and/or dependents with access to your Flex account.

NAME: _____ **SSN:** _____ **RELATIONSHIP TO EMPLOYEE:** _____

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❑ **Re - Enrolling**	
❑ **New Enrollee**	**DATE OF HIRE:** _____ **CHECK DATE OF FIRST PAYROLL DEDUCTION:** _____
❑ **Notice Of Change**	**REASON FOR CHANGE (Life Event**):** ❑ Marriage ❑ Birth or Adoption of Dependent ❑ Employment Change ❑ Other (explain)_____ ❑ Divorce ❑ Death of Dependent ❑ Benefit Change _____
❑ **Termination**	**DATE OF TERMINATION:** _____ **CHECK DATE OF LAST PAYROLL DEDUCTION:** _____

FLEXIBLE BENEFIT PLAN ELECTION

❑ **Premium Conversion Plan** Employee contributions to insurance premium will be withheld on a pre-tax basis unless otherwise requested.	*For Employer's Use Only* $_____ Pay check $ _____ Annually
❑ **Health Care Flexible Spending Reimbursement Account** You may elect withholdings not to exceed $2,500 annually.	$_____ Pay check $ _____ Annually
❑ **Dependent Care Reimbursement Account** The IRS allows a pre-tax withholding up to $5,000 per year per household ($416.66/mo) for dependent care. Age of Child(ren) _____	$_____ Pay check $ _____ Annually

Whereas, the employee desires to obtain benefits of IRS sections 105, 106, and 125 and other sections as amended that provide benefits, and whereas employer is willing to assist employee in obtaining such benefits, now, therefore, it is normally agreed employee's cash compensation **per pay check** shall be reduced by $_____* effective with the pay check issued on_____.

Employer will apply the amount by which cash compensation is reduced to provide benefits as described in the Enrollment and Election Form. If employee's employment is terminated, this agreement will terminate. I elect the benefits indicated above and authorize my employer to reduce my compensation by the amount necessary to pay for the benefits I have elected. I understand the following:

1. My election for the Health Care and Dependent Care Reimbursement Accounts may not be changed or revoked until the next plan year or a life event (change in status or income)** occurs.
2. Manual reimbursements will be processed every 5thday of the month. Eligible expenses can be processed by the "Flex Convenience" debit card. ***Save all receipts – as per guidance from the IRS, random audits will be performed.*** If ineligible expenses are discovered, the amounts to compensate for the misuse of funds will be withheld from payroll.
3. **All expenses must be submitted for reimbursement no later than three months after the end of the plan year. Once all eligible expenses have been reimbursed I forfeit any amounts left in the Health Care or Dependent Care Accounts, with the exception of the rollover allowance on my Health Care Account of up to $500.**
4. My "Flex Convenience" debit card is valid for 3 years. I will be responsible to pay a $10 replacement fee for lost or stolen debit cards.
5. Amounts reimbursed by any other source not eligible, i.e., benefits paid by insurance or through an, HSA or HRA.

_____ _____ _____ _____
Employee Signature Date Employer Signature Date

❑ I have been offered and decline this benefit at this time.

*A total of the Health Care and Dependent Care Account deposits