FLEXIBLE BENEFITS PROGRAM
Genesee Valley BOCES

ENROLLMENT FORM

**Wayland-Cohocton Central School**

Participant's Name: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Date of Birth: _____

For access to your online flexible benefit account, please include an email address.

Email Address: _____

DEPENDENTS:

| NAME | RELATIONSHIP | BIRTH DATE |
|---|---|---|
| | (SPOUSE) | |
| | | |
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As an eligible participant in the Flexible Benefits Program, I understand the benefits available to me as well as the other rights and obligations which I have under the Plan. In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amount set forth below for the plan year (or during such portion of the year as remains after the date of this agreement). I understand that I may not transfer money between options (Medical and Dependent Care Spending Accounts).

## 1. PREMIUM CONVERSION

An employee who is eligible to participate in the Plan and who is covered by the Employer's insured or self-funded benefits shall automatically become a participant to the extent of the premiums for such insurance unless the Employee completes, during the Election Period, a Waiver of Participation form. Through this waiver form the employee elects not to participate in the Premium Conversion portion of the Plan.

OVER

## 2. ELECTION OF HEALTH CARE REIMBURSEMENTS

My election will be a: (Please select one and fill in amount to be redirected.)

___ - ***General-Purpose Health FSA Option***: Medical expenses incurred by a Participant or his or her Spouse or Dependents for medical care, but only to the extent that the expense has not been reimbursed through insurance or otherwise. *(This option is available if **not** enrolled or **not** planning to enroll in a High Deductible Health Plan at any time during the Flex Plan Year.)*

___ - ***Limited-Purpose (Vision/Dental) Health FSA Option***: Medical expenses incurred by a Participant or his or her Spouse or Dependents for medical care, however such expenses are **limited to vision care and dental care only**, but only to the extent that the expense has not been reimbursed through insurance or otherwise. *(This is the only choice for those currently enrolled or plan to enroll in a High Deductible Health Plan during the Flex Plan Year.)*

Salary redirection: $_____ total for plan year. deductions taken out over 20

(General or Limited – Total set aside not to exceed $3,050) pays beginning 9/15/23

I understand that:

- Reimbursement via paper claim submission, Consumer Health portal online submission or debit card transactions will be available only for "qualifying health care expenses" as defined by the Internal Revenue Service. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.
- I cannot seek reimbursement from this account for a medical expense which I intend to take as a deduction or credit on my tax return.
- If there is still money remaining in the account after all expenses have been submitted, up to $610 can roll over into the new plan year for active and eligible employees. Any amount above $610 will be forfeited.

## 3. ELECTION OF DEPENDENT CARE ASSISTANCE

_____ I elect to receive dependent care assistance for the plan year.

Salary redirection: $_____ total for plan year.

(Maximum cannot exceed $5,000 per calendar year for a married couple filing jointly or a single parent. For a married person filing separately the maximum cannot exceed $2,500 per calendar year.)

I understand that:

- Reimbursement via paper claim submission or Consumer Health portal online submission will be available only for "dependent care expenses" as defined by the Internal Revenue Service. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.
- I will provide the Administrator with federal form W-10 for each child care provider utilized, and statements from the child care provider that includes the amount of the expense as proof that the expense has been incurred.
- I will only be reimbursed for amounts up to the balance in my account at the time of my request.
- I cannot claim a dependent care tax credit for amounts I receive as reimbursements under the Dependent Care Assistance Program.
- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year.

## OTHER TERMS AND CONDITIONS

- I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status.
- My Social Security benefits may be slightly reduced as a result of my election.
- If I fail to submit a claim within the 60-day period immediately following the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.
- I attest that all dependents named on this enrollment form meet the IRS definition of "qualifying child" or "qualifying relative" for purposes of medical reimbursement and/or dependent care assistance programs. (See IRS Publication 17)
- I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form.

_____ _____

**Employee's Signature** **Date**

Please return this form to Wayland-Cohocton Central School Business Office.