NEW PARTICIPANTS ONLY

WESTERN SUFFOLK BOCES

FLEXIBLE SPENDING ACCOUNTS 2018 ELECTION FORM

(PLEASE PRINT CLEARLY)

245 Kenneth Drive
Rochester NY 14623-4277

Phone: (800) 473-9595
www.BenefitResource.com

SCHOOL DISTRICT: WEST BABYLON SCHOOL DISTRICT

A. EMPLOYEE INFORMATION

Member ID: **54407** xxx-xx-_____ *(please provide last four digits of your social security number)*

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth date: / / Gender: ☐ Male ☐ Female

Email Address: _____
(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform to Section 125 of the Internal Revenue Code.

B. FLEXIBLE SPENDING ACCOUNTS (FSAs) *Please enter your FSA election(s) below.*

(Refer to your Plan Highlights for election maximums and Plan details) **Plan Year Election**

☐ **Medical FSA** $ _____
Plan maximum is $2650 per participating employee

☐ **Dependent Care FSA** $ _____
Plan maximum is $5000 per household

C. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid MasterCard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such follow up documentation to Benefit Resource upon request.

☐ I choose to participate in the plan.

☐ I decline to participate in the plan. *(This information is to be retained for the Employer's records only and not reported to Benefit Resource.)*

Signature:_____ Date: / / _____

D. PAYROLL DEDUCTION INFORMATION *COMPLETED BY DISTRICT PAYROLL OFFICE*

- **Medical FSA $_____Payroll Contribution x_____# of contributions**
- **Dependent Care FSA $_____Payroll Contribution x_____# of contributions**
- **Pay Date of first FSA deduction(s):_____/_____/_____**

The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.

The Beniversal Prepaid MasterCard is issued by The Bancorp Bank pursuant to license by MasterCard International Incorporated.
The Bancorp Bank; Member FDIC. MasterCard is a registered trademark of MasterCard International Incorporated.

Rev. 10/2017