

# Flexible Spending Accounts (Optional)

## Election/Change Form for CHEIBA Trust

Note: You must re-enroll in this plan each year

Employee Name \_\_\_\_\_  
Last (print) First Initial SS #

Home Address \_\_\_\_\_  
Street City State Zip Birth Date

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 \_\_\_\_\_ through \_\_\_\_\_. No election changes are allowed unless an eligible status change or approved Family and Medical Leave Act change occurs.

**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 understand the benefit options available to me and choose the election(s) checked below.

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 expenses \$ \_\_\_\_\_ per pay period x \_\_\_\_\_ # pay periods = \$ \_\_\_\_\_ per plan year

List all dependents and spouse (must be completed)

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

I understand that if I cannot reclaim this benefit compensation by the close of the plan year, because I did not incur eligible expenses while I was active in the plan, I then forfeit all remaining dollars. I also understand that my future PERA or DCPD benefits may be reduced by my participation in this plan and that all dollars elected through this plan cannot be applied as a credit or deduction on my tax return.

Employee's Signature  \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\* Add dollars to your health care account for administration fees and/or debit card fees, if applicable.

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

## Child and Dependent Care Questionnaire

- 1) Does the child/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 disabled? Yes  No  If yes to either #2 or #3, eligible expenses are limited to a maximum of \$3,000 per year for one child/dependent or \$6,000 per year for two or more children/dependents (maximum Federal tax credit). The CHEIBA Trust's maximum is \$5,000 per year.
- 3) Is your spouse a full-time student 5 months or more a year? Yes  No
- 4) Spouse's employer: \_\_\_\_\_\*

(\* Eligible expenses are limited to the income of the lesser earning spouse.)

I understand that I cannot pay my spouse or other dependent for the care of my children or dependents, and that my reimbursed expenses are limited to the income of the lesser earning spouse.

For Internal Use Only - New Elections During Plan Year

Reason for Election  New Hire  Status Change  Termination  COBRA for Health FSA  Yes  No

Eligibility Date: \_\_\_\_\_ First payroll deduction date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_