Flexible Spending Account Enrollment Form

EMPLOYER MUST FILL-IN					
Re-enrollment ___	New ___	Change ___			
Effective Date _____					
1st Deduction date _____					
1st Deduction amount _____					
Payroll Schedule	W	B	S	M	Q

I. EMPLOYEE INFORMATION - Please print clearly

Company Name: **The Diocese of Long Island**

First Name: _____ MI:_____ Last Name: _____

SSN: _____ DOB: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____

City: _____ State: _____ Zip:_____

Email: _____ Work Phone: _____

II. EMPLOYEE ELECTIONS	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Reimbursement Account	$_____._____	X	_____	=	$ _____._____ ($3300 max / $20 per pay min)
Dependent Day Care Reimbursement Account	$_____._____	X	_____	=	$ _____._____ ($5,000 max / $20 per pay min)

I understand that:

∗ This election can only be changed or revoked during the Plan Year if I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change, or revocation, of an election). The new election must be consistent with the change in status, and must be applied for within 30 days of the change and is also subject to final approval by my employer.

∗ Any amounts remaining in my reimbursement accounts at the end of the year will be forfeited.

∗ This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.

∗ The maximum exclusion under a Dependent Day Care Reimbursement Account for married individuals filing a joint return is $5,000.00 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). I will talk to my tax advisor as the IRS Form 2441 must be filed with my personal income tax return.

∗ Salary contributed into one reimbursement account cannot be transferred, and used for expenses in any other account.

∗ A new enrollment form must be completed, and signed each plan year. If I do not complete, and return an enrollment form during open enrollment, I forfeit the opportunity to participate in the election choices listed above.

∗ The contributions I have elected will be made with pre-tax salary reductions, and that such reductions reduce my compensation for Social Security benefit purposes as well as Medicare taxes.

∗ The amount of salary reductions may not be claimed on my or my spouse's income tax returns.

∗ If my employment terminates, only medical expenses incurred through my period of coverage as defined in the plan can be considered for reimbursement.

∗ All claims submitted for reimbursement are subject to substantiation requirements, and I am required to, and agree to, provide documentation as requested.

∗ If using my Prepaid Benefit card, I agree to use the card for eligible expenses only, and retain all itemized receipts/statements. I agree to read and adhere to the cardholder statement I received with the card and I understand the card is suject to inactivation if I do not comply with the provisions, or upon termination of employment.

∗ If my Prepaid Benefit card is lost/stolen or I would like additional cards there will be a $10.00 fee charged to my FSA account.

∗ Any expenses I pay for with the Prepaid Benefit card, or for which I claim reimbursement have not been nor will be reimbursed elsewhere.

∗ If the plan administrators determine that an expense I submitted for reimbursement, or used my Prepaid Benefit card for was not a qualified expense under the plan documents, I shall immediately reimburse the plan for the entire amount of the unqualified expense. If I fail to timely reimburse the plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the plan in order to reimburse the unqualified expense.

III. AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS - Please attach a copy of a voided check (not deposit slip)

☐ Check ☐ Direct Deposit ☐ Checking ☐ Savings ☐ Keep my current Direct Deposit information.

∗ If a deposit slip is submitted to BAI, we will automatically change your method of reimbursement to check. If you are new and check off Direct Deposit but do not submit a check or you submit a deposit slip, your method of reimbursement will be changed to check.

∗ I, hereby, authorize Benefit Analysis Inc., to initiate debits and/or credits to or from my bank account listed on my check, and to debit and credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

∗ The authorization is to remain in full force and effect until Benefit Analysis Inc., has received written notification from the employee above.

∗ It may take up to 72 business hours to have your reimbursement appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. Benefit Analysis, Inc. shall not be responsible for any checks, or other debt obligations you make whereby you have assumed these funds are available.

∗ If a direct deposit is returned to Benefit Analysis, Inc. we will charge a $35.00 reissue fee assessed to the employee. If you do not attach a voided check we will assume you have elected to be reimbursed via check. If a check is lost or stolen, there will be a $35.00 stop payment fee assessed to the employee to reissue the check.

Signature _____ Date _____