Flexible Spending Accounts

ELECTION FORM

EMPLOYEE INFORMATION (Please Print Clearly)

Employer:	**Day & Ross**				
Last Name:		First Name:		M.I.:	
Street Address:					
City:		State:		Zip Code:	
Social Security #:		Date of Birth:		Date of Hire:	
Preferred Phone #:		Work: ☐ Home: ☐ Mobile: ☐		Hours Worked Per Week:	
Email:		Married: ☐ Single: ☐		Male: ☐ Female: ☐	
Plan Year:	**June 1, 2020 - April 30, 2021**		Effective Date:		

ELECTIONS

Health Care Flexible Spending Account – Plan Year Maximum: $2,400.00

My Annual Election: $ ÷ by # of Payroll Deductions: = $ Per Pay Check

Up to $500.00 of FSA funds not used will roll-over to the next plan year after the conclusion of the run-out period.

Dependent Care Flexible Spending Account – Plan Year Maximum: $4,500.00

My Annual Election: $_____ ÷ by # of Payroll Deductions: _____ = $_____ Per Pay Check

☐ Waive Coverage – If a change in status occurs, I may have the right to enroll in the plan at that time (if plan allows).

DEPENDENT INFORMATION

	Last Name	First Name	M.I.	Social Security #	Date of Birth	Gender
Spouse						Male: ☐ Female: ☐
Dependent						Male: ☐ Female: ☐
Dependent						Male: ☐ Female: ☐
Dependent						Male: ☐ Female: ☐
Dependent						Male: ☐ Female: ☐

CERTIFICATION

I hereby agree that my cash compensation will be redirected by the amounts set forth above for each pay period during the plan year (or during such portions of the year as remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan. I understand that:

1. Contributions will be deducted from my paycheck on a pre-tax basis. Salary reductions must be reimbursed for qualified expenses incurred during the plan year.
2. The election(s) I make will remain in effect until the end of the plan year. Changes will only be permitted if there is a change in family status (e.g., marriage, divorce, death of spouse or dependent, birth or adoption of child, or if you or your spouse experience a change in employment).
3. Health Care FSA: If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference will carry-over to the next plan year up to a $500 max, funds in excess of the $500 will be forfeited.
4. FSA Dependent Care: If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amount reverts to the plan sponsor; unused funds may not be carried over into future plan years.
5. Incurred expenses must not be covered by any other source, such as insurance, and proper documentation must be provided to receive payment.
6. My account(s) will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan. By signing and dating below, I agree to the terms and procedures listed herein and I verify that I have read and agree to the information included on this form. I hereby certify I am the spouse, parent, legal guardian of the dependent(s) shown above. *Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for benefits is guilty of a crime and may be subject to fines and confinement in prison.*

*By typing in your name, this is your electronic signature acknowledgment

_____ _____

Signature Date

CareFlex 205 W. Dares Beach Road, Prince Frederick, MD 20678
888-577-2762 (Phone) ✦ 410-414-8432 (Fax) ✦ support@careflex.com ✦ www.careflex.com

Flexible Spending Accounts ELECTION FORM

QUALIFIED EXPENSE WORKSHEET

Use the below worksheet(s) to determine the amount of money you will spend for medical and/or dependent care for you and your dependents in the upcoming plan year.

Health Care FSA – Use this worksheet to estimate eligible health care expenses that you, your spouse and your qualified dependents will incur during the plan year. The worksheet below contains some of the most common expenses. For a more comprehensive list of eligible expenses, please visit www.careflex.com.

Sample Health Care FSA Expenses	Estimated Annual Amount
Medical Insurance Deductible Payments	$
Office Visit Co-Payments	$
Prescription Drugs	$
Physical Therapy / Chiropractic Care	$
Well Child Care	$
OB/GYN Exams	$
Physicals	$
Immunizations	$
Hearing Aids / Batteries / Exams	$
Over-the-Counter (OTC) Medicines and Supplies – REMINDER: Effective January 1, 20ll, new plan provisions take effect for over-the-counter medications; please review your enrollment materials before calculating your election.	$
Dental Insurance Deductible Payments	$
Exams	$
Fillings	$
Root Canals	$
Crowns	$
Bridges	$
Dental Implants	$
Dentures	$
Orthodontics	$
Vision Exams	$
Eyeglasses	$
Contact Lenses / Supplies	$
Prescription Sunglasses	$
Laser Eye Surgery	$
Total anticipated health-related expenses:	$
Divide total anticipated expenses by # of pay periods in the Plan Year:	
Deduction Amount Per Pay Period:	**$**

Dependent Care FSA – Use this worksheet to estimate your eligible child and dependent care expenses. Eligible dependents include your dependent child(ren) through age 12 and/or dependent(s) who is physically or mentally disabled and spends at least 8 hours a day in your home. The annual pre-tax family contribution limit is the lesser of $5,000 married filing jointly or single parent ($2,500 if filing separately), the employee's earned income for the year or the spouse's earned income.

Sample Dependent Care FSA Expenses	Estimated Annual Amount
Dependent Care Center Fees (Qualifying Child or Adult Daycare)	$
Nursery / Pre-School Fees (excluding Kindergarten)	$
Before and/or After School Care	$
In-Home Dependent Care	$
Summer Day Camp (excluding overnight camp)	$
Caregiver's Wages and Employer Taxes	$
Total anticipated dependent care expenses:	$
Divide total anticipated expenses by # of pay periods in the Plan Year:	
Deduction Amount Per Pay Period:	**$**

Submit

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