FSA/Dependent Care Combined Enrollment Form

HealthSmart Benefit Solutions

Instructions

1. Complete the Form :

Group Name: **MERCER COUNTY COMMUNITY COLLEGE** Group # **JSL 19114** Plan Year **January 1, 2023 to December 31, 2023**

Employee Name: _____Social Security Number: _____

Email Address: _____

Address: _____ Gender: _____ Female _____ Male

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Payroll Frequencies: Bi-weekly (24) Bi-weekly (20)

	Per Pay Period Election:	**Annual Election:**
Healthcare Reimbursement Enrollment: ***(Note: Do not include premium contributions in this amount)*** Total Amount Desired to Fund Healthcare Flexible Spending Account Maximum annual election ($2,750, subject to change by the IRS)	$ _____	$_____
Dependent Care Reimbursement Enrollment: ***(i.e., after school childcare, preschool, etc.)*** Total Amount Desired to Fund Dependent Care Flexible Spending Account (max. annual election $5,000)	$ _____	$_____

Include Debit Card ☐ Yes ☐ No (If you already have a card, please do not check a box, see card regarding expiration date) Additional cards may be ordered for dependents over the age of 18, please list the dependent information below to receive the additional cards (fee may apply):

Name(s); Date(s) of Birth (DOB); and Relationship of Dependents:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Debit Card Authorization Agreement (if elected above): The Plan requires a certification upon enrollment and each plan year thereafter that the debit card will only be used for eligible expenses of the employee and the employee's spouse and dependents. As the plan participant, I certify that any expense paid with the debit card has not been reimbursed and that as the participant I will not seek reimbursement under any other plan covering these benefits. As the Plan participant, I also agree to acquire and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts and will submit them to HealthSmart as required per the IRS' documentation standards to validate my purchase. I further certify that if I should purchase items using my debit card that are not deemed to be eligible expenses, I authorize my employer, or HealthSmart on my employer's behalf, to collect the improper payment from me. If this option is unsuccessful, I understand that I will be denied access to the card's usage until the debt is repaid by me.

Enrollment Authorization: By signing I certify that I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the plan year this agreement is irrevocable and cannot be changed accept under special circumstances as outlined in the Summary Plan Description. I understand that, except for certain family situations as defined by the SPD, my participation in this Plan is for the entire Plan Year. I understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease. I understand this redirection may have minimal effect on my Social Security Benefits. I understand that amounts redirected into this account may not be used in any other benefit plan, refunded or carried over to the following year. Reimbursement will be available only for qualified health care expenses as described in the Summary Plan Description. I agree to notify my employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. Prior to the beginning of each Plan Year, I will be given an opportunity to change the amount of my election or revoke my participation. If I do not submit a new election, my coverage will end with plan year of this election. The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Service. This agreement is subject to the terms of the Employer's Flexible Benefit Plan as may be amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under the applicable laws, and revokes any prior election and salary reduction agreement (if any) relating to such a plan.

_____ _____

Employee Signature Date

Administrative Use Only

☐ **Division** _____ ☐ **Location** _____

Hire Date: _____ **Effective Date:** _____ **First Deduction Date:** _____

_____ _____

Employer Signature **Date**

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