



# Lane ESD 2022-23 FSA Enrollment Form

You will be making elections for the **October 01, 2022** through **September 30, 2023** Plan Year. After completing this form, please sign, date, and return it to your Human Resources Department on or before the end of your enrollment period.

SECTION A: PARTICIPANT PROFILE – <i>Please Print Legibly</i>		
First Name	Home Phone ( ) -	
Middle Initial	Work Phone ( ) -	
Last Name	Date of Birth (mm/dd/yyyy) / /	
Social Security Number	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Email Address	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner	
Address Line 1	Address Line 2	
City	Date of Hire (mm/dd/yyyy) / /	
State	Zip Code	Division (if applicable)
Are you enrolling a Domestic Partner? <input type="checkbox"/> No <input type="checkbox"/> Yes (Name: / SSN: )		

SECTION B: PLAN INFORMATION – <i>Please Print Legibly</i>		
<b>Healthcare – Flexible Spending Account (FSA)</b> Out-of-pocket medical, dental, and vision expenses. Contribute up to \$2,850 for the plan year (Min \$0).  <i>Important Note Regarding Registered Domestic Partnerships (RDP):</i> The total amount that may be contributed by an employee who has a same-sex RDP to the Federal FSA plus State FSA must be no greater than the amount that could be contributed to a Federal FSA.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Employee (Fed + State): \$ _____ + RDP (State Only): \$ _____ = <b>Total:</b> \$ _____
<b>Limited Healthcare – Flexible Spending Account (LMT)</b> <b>For HSA Enrollees</b> – Used for dental and vision expenses only. Contribute up to \$2,850 for the plan year (Min \$0).	<input type="checkbox"/> Yes <input type="checkbox"/> No	Employee (Fed + State): \$ _____ + RDP (State Only): \$ _____ = <b>Total:</b> \$ _____
<b>Dependent Daycare – Flexible Spending Account (DCA)*</b> Child (covered up to 13 <sup>th</sup> birthday) and/or adult daycare expenses. If married filing jointly or single – Contribute up to \$5,000 for the plan year. If married filing separately – Contribute up to \$2,500 for the plan year (Min \$0).  <small>*IRS regulations state that a participant may only elect a maximum of \$5,000 per calendar year (January thru December). If your plan runs off-calendar or if you are enrolling in a short plan year, keep this in mind when making your election(s).</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Employee (Fed + State): \$ _____ + RDP (State Only): \$ _____ = <b>Total:</b> \$ _____

DEPENDENT INFORMATION		
My Dependents:		My Domestic Partner's Dependents (if applicable):
Spouse Name	DOB / /	Child Name
Child Name	DOB / /	Child Name
Child Name	DOB / /	Child Name
Child Name	DOB / /	Child Name
Child Name	DOB / /	Child Name

SECTION C: PARTICIPANT AUTHORIZATION	
I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amount(s) I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all acknowledgements & authorizations provided by Chard Snyder for each plan/option elected above on the back of this form.	
Signature	Date / /

HR USE ONLY (FOR MID-YEAR NEW HIRES) – <i>Must be completed by HR Rep prior to sending to Chard Snyder</i>		
Employee Effective Date / /	1 <sup>st</sup> Contribution Date / /	Initials

## PARTICIPANT ACKNOWLEDGEMENTS & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate in the plan/option.

### FLEXIBLE SPENDING ACCOUNT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above) and submit my claims by the end of the run out period or the funds will be forfeited. If my plan provides a carryover, funds remaining in my FSA reimbursement account will be carried over into the new plan year up to my plan's allowed carryover maximum. Funds remaining above my plan's allowed carryover maximum will be forfeited.
- I cannot change my election once the Plan Year begins; my election(s) must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

### BENEFIT CARD – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I have received, reviewed and understand the procedures of this benefit card.
- Benefit card funds are authorized only for the payment of qualified expenses as outlined in my employer's plan document.
- The benefit card may be used only for eligible expenses at the point-of-service, and I may be required to submit a claim form with receipts and/or bills to Chard Snyder to substantiate the expense.
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled.
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.
- If I use my benefit card for ineligible expenses, I will be required to pay back the amount that was not covered by my plan.
- If I do not repay amounts used for ineligible expenses, my employer and/or Chard Snyder has the right to cancel my benefit card and deduct this amount from my salary.
- These funds have not or will not be reimbursed under any other plan coverage.
- Chard Snyder will not be held responsible for processing duplicate claims that I have submitted in error.
- The benefit card may not be accepted at all merchants that accept MasterCard.
- I must check with my employer to verify the monthly fee, if any, to add to the benefit card.

I understand and agree to the terms and conditions specified on this form and authorize Chard Snyder to complete my request as indicated.