COUNTY OF SONOMA

# 2020 Flexible Spending Account (FSA) Program
# COVID-19 Change in Election Authorization Form

Employee Name _____ Employee ID # _____
Please Print *Required*

Mailing Address _____ Email Address _____
Street

_____
City State Zip

Office/Department _____ Work/Cell Phone # _____

Participants have a one-time opportunity to enroll, revoke, increase or decrease their FSA elections at any time during the remainder of the 2020 plan year without providing a reason due to COVID-19. The new annual election amount must be equal to or greater than what a participant has contributed year to date and amounts already reimbursed from the plan. Refunds of contributions are not permitted.

Enrollment elections and changes are effective the first of the month following the date the Human Resources Benefits Unit receives your completed form and are subject to payroll processing deadlines. Only eligible expenses incurred during the Coverage Period are eligible for reimbursement. At the end of the plan year, eligible participants with remaining Health FSA funds may carry forward up to $550 of unused Health FSA funds into the next plan year. Any unused funds in excess of $550 will be forfeited.

**Pre-Tax FSA Benefit Election Change** *Annual Election Amount changes will be matched to total of claims paid and will be limited to amounts no less than the amount already reimbursed as of the pay date change effective date.

Health FSA Plan - Annual Max: $2,750

☐ **Enroll** ☐ **Revoke** ☐ **Increase** ☐ **Decrease**

**Current Annual Election Amount** $ _____ **New Annual Election Amount** $ _____

Dependent Care Assistance Plan - Annual Max: $5,000 ($2,500 for married filing separate)

☐ **Enroll** ☐ **Revoke** ☐ **Increase** ☐ **Decrease**

**Current Annual Election Amount** $ _____ **New Annual Election Amount** $ _____

## Authorization and Agreement

I hereby elect the benefit(s) indicated above. I have read and understand the plan informational materials and I authorize the County of Sonoma to deduct the elected pre-tax Annual Election Amount during the plan year. Bi-weekly contributions withheld will be based on the Annual Election Amount and the number of pay periods remaining in the plan year. If my new annual election amount is lower than my total claims paid on the pay date change effective date, I acknowledge my annual election amount will be adjusted to the total claims paid and my bi-weekly contributions will be adjusted accordingly **I understand that this election is binding and cannot be revoked or modified for the current plan year, except within 31 days of a qualifying change in family or work status event** (e.g., marriage, divorce, birth). I further understand that any remaining funds that are not used for eligible expenses incurred during the **Coverage Period**, in excess of the Health FSA carryover of $550, will be forfeited in accordance with the current plan provisions and tax laws.

Employee Signature _____ Date _____

**Return this form to the Human Resources Benefits Unit at benefits@sonoma-county.org or fax to (707) 565-1139.**

**FOR COUNTY USE ONLY:**

Effective Date _____ eP Effective Date _____ eP Eligibility Start Date _____ eP Eligibility End Date _____

eP Premium Start Date _____ eP Premium End Date _____ Date Entered in eP _____ Initials _____

Review Date _____ Initials _____ Vendor Verification _____ Initials _____