



**2020 Flexible Spending Account (FSA) Program
Enrollment and Salary Reduction Authorization Form**

Annual Enrollment

New Hire/Newly Eligible Date _____

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

Mailing Address _____ Street _____ Email Address _____

City _____ State _____ Zip _____

Office/Department _____ Work Phone # _____

Pre-Tax FSA Benefit Election

Flexible Spending Account Plan Type	Annual Election Amount
<input type="checkbox"/> Health FSA Plan (Medical, dental, and vision expenses that are only partially covered or not covered at all by your insurance. e.g., doctor co-payments, eye glasses)	\$ _____ Annual Election Amount (Bi-weekly contribution is calculated by dividing the annual election amount by the remaining number of pay dates in the calendar year) Annual Maximum: \$2,750 Bi-weekly Minimum: \$5.00 per pay period
<input type="checkbox"/> Dependent Care Assistance Plan (e.g., day care expenses, elder care expenses) Dependent Care Expenses must be provided to qualified persons, defined as: (a) A dependent under age 13; (b) A spouse who is physically or mentally unable to care for himself or herself; (c) A dependent who is unable to care for himself or herself and who qualifies as a dependent for income tax purposes.	\$ _____ Annual Election Amount (Bi-weekly contribution is calculated by dividing the annual election amount by the remaining number of pay dates in the calendar year) Annual Maximum: \$5,000 (\$2,500 for married participants filing a separate tax return) Bi-Weekly Minimum: \$5.00 per pay period

All eligible expenses must be incurred during the 2020 plan year, January 1, 2020 through December 31, 2020. Claims must be submitted for reimbursement no later than March 31, 2021. At the end of the plan year, eligible participants with remaining Health FSA funds may carry forward up to \$500 of unused Health FSA funds. The carry forward funds can be used for eligible health expenses in the following plan year. Any unused funds in excess of \$500 will be forfeited.

January 1, 2020 is the **Effective Date of Coverage** for all elections made during the **Annual Enrollment Period** (October 21, 2019 – November 8, 2019). For any enrollment elections/changes made during the 2020 plan year, the **Effective Date of Coverage** is the **first of the month following the election/change**. **Coverage ends when contributions stop, last day of employment** or at the end of the current plan year, whichever comes first. Only eligible expenses incurred during the **Coverage Period** are eligible for reimbursement.

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. **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 \$500, will be forfeited in accordance with the current plan provisions and tax laws.

Employee Signature _____ Date _____

Return this form to your Department Payroll Clerk and keep a copy for your files. Your Payroll Clerk will submit all forms to the Human Resources Benefits Unit

FOR COUNTY USE ONLY:					
Coverage Begin Date	January 1, 2020	Mid-year Start	Effective Date	_____	# of Pay Periods _____
Eligibility Start Date	_____	Premium Start Date	_____	Date Entered in eP	_____
				Initials	_____