



## 2021 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 2021 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 unused Health FSA funds into the 2022 plan year.

**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.

<u>Health FSA Plan</u> (\$130 - \$2,750)	
<input type="checkbox"/> <b>Enroll</b>	<input type="checkbox"/> <b>Revoke</b>
<input type="checkbox"/> <b>Increase</b>	<input type="checkbox"/> <b>Decrease</b>
<b>Current Annual Election Amount</b> \$ _____	<b>New Annual Election Amount</b> \$ _____
<u>Dependent Care Assistance Plan</u> (\$130 - \$10,500)	
<input type="checkbox"/> <b>Enroll</b>	<input type="checkbox"/> <b>Revoke</b>
<input type="checkbox"/> <b>Increase</b>	<input type="checkbox"/> <b>Decrease</b>
<b>Current Annual Election Amount</b> \$ _____	<b>New Annual Election Amount</b> \$ _____

### 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).**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return this form to the Human Resources Benefits Unit at [benefits@sonoma-county.org](mailto: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 _____