COUNTY OF SONOMA

2019 Flexible Spending Account (FSA) Program
Enrollment and Salary Reduction Authorization Form

☐ **Annual Enrollment** ☐ **New Hire/Newly Eligible Date** _____

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

Mailing Address _____ Email Address _____
Street

_____
City State Zip

Office/Department _____ Work Phone # _____

Pre-Tax FSA Benefit Election

Flexible Spending Account Plan Type	Annual Election Amount
☐ **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: $2,700** **Bi-weekly Minimum: $5.00 per pay period**
☐ **Dependent Care Assistance Plan** (e.g., day care expenses, elder care expenses) Dependent Care Expenses must be provided to qualified persons, defined as: (a) A dependent under age 13; (b) A spouse who is physically or mentally unable to care for himself or herself; (c) A dependent who is unable to care for himself or herself and who qualifies as a dependent for income tax purposes.	**$_____ 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 2019 plan year, January 1, 2019 through December 31, 2019, and claims must be submitted for reimbursement no later than March 31, 2020. At the end of the plan year, eligible participants with remaining Health FSA funds may rollover up to $500 of unused Health FSA funds. The rollover 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, 2019 is the **Effective Date of Coverage** for all elections made during the **Annual Enrollment Period** (October 8, 2018 – October 26, 2018). For any enrollment elections/changes made during the 2019 plan year, the **Effective Date of Coverage** is the **pay date when the first contribution amount is withheld**. **Coverage ends when contributions stop** 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, 2019 ☐ Mid-year Start Effective Date _____ # of Pay Periods _____

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