Western Suffolk BOCES

ENROLLMENT/CHANGE FORM - FLEXIBLE SPENDING ACCOUNTS

School Name

Effective Date of Enrollment *(MM/DD/YYYY)*

Employee Name

Birth Date *(MM/DD/YYYY)*

Member ID *(provide last four digits of your SSN)*

x x x - x x - ☐☐☐☐

Email Address

Street or PO Box

Phone Number

City

State

ZIP

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform to Section 125 of the Internal Revenue Code.

Please enter your FSA election(s):

Refer to your Plan Highlights for election maximums and Plan details.

Plan Year Election

☐ **Medical FSA (Plan maximum is $3,050 per participating employee)**
Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.

☐ **Dependent Care FSA (Plan maximum is $5,000 per household)**

This is a:

☐ New enrollment ☐ Change in previous enrollment

If this is a change in enrollment, please check the event that triggered this change:

NOTE: An election can only be changed if the change in status affects eligibility for that coverage. Any change in election must be consistent with the change in status and the change in eligibility

- ☐ Participant's termination of employment.
- ☐ Change in employment status of spouse or dependent (including termination or commencement of employment).
- ☐ Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).
- ☐ Change in number of tax dependents (including birth, adoption, placement for adoption, death).
- ☐ Change in work schedule (reduction/increase in hours by employee, spouse or dependent, including a switch between full-time/part-time, a strike/lockout, and commencement of or return from an unpaid leave of absence).
- ☐ Change in residence or worksite (of employee, spouse, or dependent).
- ☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).
- ☐ Change in dependent care cost or provider (for Dependent Care FSA elections only).
- ☐ Other:

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PLEASE CERTIFY THE FOLLOWING:

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may besuspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck onan after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

☐ I choose to participate.

☐ I decline to participate. *(This information is retained for the Employer's records only and not reported to Benefit Resource.)*

Signature ____________________ Date *(MM/DD/YYYY)* ____________

EMPLOYERS ONLY - This section must be complete for employee to be enrolled

Medical FSA $ ________ payroll contribution x ________ # of contributions

Dependent Care FSA $ ________ payroll contribution x ________ # of contributions

Pay date of first FSA deduction(s): ________________

Your Member ID is your 5-digit District ID (see below) plus the last four digits of your Social Security Number. Do not use spaces or dashes.

District ID	School District	District ID	School District	District ID	School District	District ID	School District
54381	Amityville	54392	Deer Park	54400	Kings Park	54406	Pt. Jefferson
54382	Babylon	54412	Deer Park Library	50128	Levittown	50126	Rocky Point
54384	Bay Shore	54414	East Mdw Library	55652	Lindenhurst	50122	Syosset
54385	Bellmore Merrick	54394	Eastport So Manor	54401	Massapequa	50124	Valley Stream 30
50123	Bethpage	54396	Elwood	50121	Merrick	50125	Valley Stream CSH
54386	Center Moriches	54397	Farmingdale	54402	North Babylon	50123	Valley Stream 24
54387	Central Islip	50127	Garden City	54403	North Bellmore	54407	West Babylon
54388	Cold Spring Harbor	50120	Herricks UFSD	54404	North Merrick	54408	West Islip
54389	Commack	54398	Hauppauge	54405	Northport	55659	Western Suffolk BOCES
54390	Connetquot	55653	Island Park	54417	Plndg Public Library	54409	William Floyd
54391	Copiague	54415	Jericho Public Library	54419	Plnvew Bthpg Library		

The Beniversal Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark, and the circles design is a trademark of, Mastercard International Incorporated. The Beniversal card is accepted at qualified merchants accepting Debit Mastercard. The Bancorp Bank; Member FDIC. The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.

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