FLEXIBLE SPENDING ACCOUNTS

Your employer offers two types of Flexible Spending Accounts (FSAs):

Health Care and Dependent Day Care

These accounts provide a way to pay for certain types of expenses on a pre-tax basis.

What You **NEED TO KNOW**……..

The IRS released new guidance modifying the longstanding "use it or lose it" rule for Health FSAs. The new rule allows taxpayers to carryover up to $610 of their unspent FSA funds to the following plan year. You may now elect a Health FSA of at least $610 without worry of losing it!

Health Care FSA

- ✓ Due to health care reform, the maximum amount you may contribute to a Health Care FSA will be $3,050 per year.
- ✓ You may use the FSA even if your family is not enrolled in your employers benefit plan.
- ✓ A Health Care FSA is a great way to save for out-of-pocket health care expenses, because you contribute a small amount each pay period, rather than all at once.
- ✓ The money you contribute from each paycheck is deducted before taxes – no federal, state or SSN taxes will be withheld from any of those dollars – saving you up to 30 cents for each dollar.

Dependent Day Care FSA

- ✓ You can contribute up to $5,000.00 into your Dependent Day Care FSA for the current Plan year.
- ✓ Dependents eligible for care can be your children up to age 13 or any other dependents (including a parent or in-law)who are not able to care for themselves because of a disability and who spend at least eight hours per day in your home.
- ✓ If required by law, a dependent care facility must be registered or licensed in order for you to receive reimbursement under the FSA program.
- ✓ If you employ an independent child care provider, you must provide their SSN or tax ID number and issue them a 1099 in order for you to receive reimbursement.

Cafeteria Plan Election Form

Last Name (Please Print) _____ First Name _____

Address_____City_____State _____ Zip _____

Social Security Number_____Home Phone (_____)_____Work Phone (_____)_____

email Address _____

I hereby authorize and direct my employer_____ to reduce my earnings in the amount necessary to fund my Cafeteria Plan as indicated below. I understand such reductions, considered elective contributions under the Plan, will start with my first paycheck dated after 1/1/17. I understand that the purpose of this program is to allow employees to select qualified benefits within the guidelines of the Internal Revenue Code. I also understand the flexible spending account (FSA) plan(s) will allow me to be reimbursed for eligible out-of-pocket medical, dental, vision, and/or dependent care expenses and that out-of-pocket medical expense no longer include over-the-counter medicines unless first prescribed by a physician. I understand that the any amount over $500 in my FSA accounts after 12/31 will be forfeited.

Your insurance premiums are automatically pre-taxed

I choose to participate in Flexible Spending Account (FSA) Elections

FSA Medical Expenses (Max. $3,050)	**$_____ (Annual Amt.)**	**$ _____ (Per-Pay-Period)**
Dependent Care (Child Care) (Max. $5,000)	**$_____ (Annual Amt.)**	**$ _____ (Per-Pay-Period)**
Total Elected Amounts	**$_____ (Annual Amt.)**	**$ _____ (Per-Pay-Period)**

I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the Plan year, unless the revocation and new election are on account of and consistent with a change in family status. I hereby certify the above information to be correct and true and choose to participate.

Signature: _____ Date: _____