Flexible Spending Accounts (Optional)

Election/Change Form for CHEIBA Trust

Note: You must re-enroll in this plan each year

Employee Name _____
Last (print) First Initial SS #

Home Address _____ / /
Street City State Zip Birth Date

Home Phone _____ Work Phone _____ College/Agency _____

Email Address: _____

PURPOSE: This agreement is designed to allow an employee to convert a portion of his/her taxable earnings to a tax-free benefit status, pursuant to a Code Section 125 plan and other codes listed under a Flexible Benefit Plan.

AGREEMENT: The employer and employee mutually agree to this election. It is a binding agreement effective _____ through _____. No election changes are allowed unless an eligible status change or approved Family and Medical Leave Act change occurs.

LIMITATIONS: Termination of employment with this employer terminates this agreement. Only expenses not reimbursed to the employee by any other insurance plan or company plan may be considered qualified expenses under the Flexible Benefit Plan.

I understand the benefit options available to me and choose the election(s) checked below.

I elect to reduce my gross wage and redirect the following dollars into the appropriate spending account(s) below:

a. * Health care expenses. If you are paid 10 pay checks (January – May and August – December) health care expenses $ _____ x 10 pay periods = $ _____ per plan year ($2,750 Maximum)
b. Health care expenses. If you are paid 12 pay checks (January– December) health care expenses $ _____ x 12 pay periods = $ _____ per plan year ($2,750 Maximum)

c. ** Dependent care (child care) expenses. If you are paid 10 pay checks (January – May and August – December) dependent care expenses $ _____ x 10 pay periods = $ _____ per plan year ($5,000 Family Maximum)
d. Dependent care expenses If you are paid 12 pay checks (January– December) dependent care expenses $ _____ x 12 pay periods = $ _____ per plan year ($5,000Family Maximum)

List all dependents and spouse/ tax qualified domestic partner (must be completed)

	Name	Date of Birth	Relationship
1.			
2.			
3.			
4.			

I understand that if I cannot reclaim this benefit compensation by the close of the plan year because I did not incur eligible expenses while I was active in the plan, I then forfeit all remaining with the exception of a one year $550 health care rollover. I also understand that my future PERA or MDCP benefits may be reduced by my participation in this plan and that all dollars elected through this plan cannot be applied as a credit or deduction on my tax return.

Employee's Signature ***X*** _____ Date _____/_____/_____

** Complete the child and dependent care questionnaire if you plan to use the dependent care spending account.

Child and Dependent Care Questionnaire

1)	Does the child/dependent live in your home at least 8 hours each day?	Yes ☐	No ☐	If yes, expenses are eligible for this plan.
2)	Is your spouse/tax qualified domestic partner disabled?	Yes ☐	No ☐	If yes to either #2 or #3, eligible expenses are limited to a maximum of $3,000 per year for one child/dependent or $6,000 per year for two or more children/dependents (maximum Federal tax credit). CHEIBA Trust maximum is $5,000 per year
3)	Is your spouse/tax qualified domestic partner a full-time student 5 months or more a year?	Yes ☐	No ☐	
4)	Spouse's/Tax qualified domestic partner's employer: _____*			

(* Eligible expenses are limited to the income of the lesser earning spouse/partner.)

I understand that I cannot pay my spouse/tax qualified domestic partner or other dependent for the care of my children or dependents and that my reimbursed expenses are limited to the income of the lesser earning spouse.

For Internal Use Only - New Elections During Plan Year

Reason for Election ☐ New Hire ☐ Status Change ☐ Termination COBRA for Health FSA ☐ Yes ☐ No

Eligibility Date: _____ First payroll deduction date: _____