FAIRFIELD COUNTY 2016 FLEXIBLE SPENDING PLAN ELECTION FORM

Effective: January 1, 2016

Name:_____Department: _____

To Decline Enrollment:

☐ **I decline participation in the Flexible Reimbursement Accounts**.

Signature:_____ **Date:**_____

To Enroll :

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____

Name of Beneficiary:_____Relationship: _____

Address (If different than address listed above):_____City:_____State:_____Zip: _____

☐ **I elect to contribute $ _____ X 26** pays for an annual election of **$ _____ for the 2016 plan year for my Health Care Flexible Spending Account**. (Maximum of $2,500) This amount will be set aside before taxes are calculated to reimburse me for qualified out-of-pocket health care expenses for myself and/or my qualified dependents.

☐ **I elect to contribute $ _____X 26** pays for an annual election of **$ _____ for the 2016 plan year for my Dependent Care Flexible Spending Account.** (Maximum of $5,000/family or $2,500 if married, filing separately) This amount will be set aside before taxes are calculated to reimburse me for qualified dependent day care expenses.

Special Features:

☐ I elect to have my reimbursements **directly deposited** into my checking or savings account. Please use the routing and account numbers that are located at the bottom of your checks.
Routing Number:_____ Account Number: _____

☐ I elect to receive the **Flex "Benny" Convenience Card**. I understand $1.50 per month will be deducted from my paycheck.

****Please note if you do not elect one of the above features, you will receive a paper check for your reimbursement. This will delay the process of receiving reimbursement.**

I understand that this election will be in effect for the entire plan year, unless I experience a "Change in Status" as defined by the IRS. I further understand that any amounts in my account not used for eligible expense incurred during the plan year will be forfeited at the end of the plan year based on current tax regulations. I agree that I will only submit claims for my qualified tax-dependents.

_____ _____

Signature of Employee Date