Flexible Spending Enrollment Form

RETURN THIS FORM TO CITY OF MADISON HUMAN RESOURCES

Employee (Participant) Name: _____

Employee ID Number (MUNIS EE#)*: _____

Date of Birth (MM/DD/YYYY): _____ **Last 4 Digits of SSN:** XXX-XX-

Department Name: _____

Employee (Participant) Address:

Street Number and Name_____

City, State, Zip_____

Email Address:** _____

Primary Phone Number:** _____

Alternate Phone Number: _____

Participant's Plan Effective Date: _____

*You can find your Employee ID Number on your paycheck/direct deposit advice. Your Employee ID Number will also be used as your ConnectYourCare Participant ID.

**Required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

ELECTION AMOUNTS

Prior to completing your election amounts, refer to the instructions and frequently asked questions on page 2.

I request the following amount(s) to be deducted pre-tax from my pay: **Annual Election Amount*****

1. **Medical (Out of Pocket) Expenses ($2,750 max.)** $_____
   This amount is usually paid per year towards deductible and co-insurance portions of health insurance, dental expenses, orthodontia expenses, eye care, and other healthcare related expenses.

2. **Dependent Day Care ($10,500 max.)** $_____
   Amount paid for day care expenses per year.

***Indicate the amount that you want to contribute for the full year. Your employer will calculate the amount per paycheck.

AUTHORIZATION

I agree to have my pay reduced by the election/deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Spending deduction(s) will be in effect for the entire Plan Year and cannot be changed or revoked except as permitted by federal law. I understand that my election will be automatically deducted before taxes. I understand additional Flex Spending Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s). I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the Flex Spending Card or termination of employment, I will immediately return all Flex Spending Cards to my Employer. I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support.

Signature _____ Date _____

CYC • 307 International Circle Suite 200 • Hunt Valley, MD 21030 • 877-292-4040 • Fax: 443-681-4601 • www.connectyourcare.com

ENROLLMENT FORM INSTRUCTIONS

1. Complete each applicable line on the enrollment form, sign, and date. Please print legibly.
2. Return the completed and signed form to your employer: Human Resources Department, Suite 261, Madison Municipal Building, 215 Martin Luther King Jr. Blvd., Madison, WI 53703. Forms may be faxed to (608) 267-1115 or emailed to benefits@cityofmadison.com (please use email encryption).
3. For enrollment assistance, contact Human Resources at (608) 266-4615 or benefits@cityofmadison.com.
4. **Healthcare Flexible Spending Account Expenses**: The annual amount elected is typically paid toward eligible deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eye care, and other miscellaneous healthcare expenses. Per IRS regulations, a Participant may salary reduce the **maximum of $2,750 for the 2021 plan year**. There is no minimum election. Indicate your full annual election amount. Write 0.00 on the Medical (Out of Pocket) Expenses line if you do not wish to participate in the Healthcare FSA for the 2021 plan year.
5. **Dependent Care Assistance Program**: Amount paid for eligible dependent care expenses per year. The maximum allowable amount under IRS regulations is $10,500 for the 2021 calendar year per family. The 2021 plan year maximum for married individuals filing as single is $5,250. There is no minimum election. Indicate your full annual election amount. Write 0.00 on the Dependent Day Care line if you do not wish to participate in the Dependent Care Assistance Program for the 2021 plan year.

QUESTIONS FREQUENTLY ASKED BY EMPLOYEES

1. **What does participating in a Healthcare FSA or Dependent Care Assistance Program (DCAP) account do for me?** These accounts offer you a choice to pay for certain eligible expenses on a pre-tax basis. Paying for eligible expenses with pre-tax dollars reduces the amount you pay in taxes and increases your take-home pay. Every dollar paid on a pre-tax basis results in a savings to you.
2. **Is there any cost or fee to me, as an employee, to participate?** No, any administrative fees are paid by the employer.
3. **Must I participate in my employer's health insurance program in order to participate in flexible spending?** No. Healthcare FSAs and DCAPs are not tied to any insurance plan or company. You may participate in a Healthcare FSA or DCAP regardless of your particular insurance provider.
4. **What are qualified medical expenses?** Qualified expenses include dental care, prescriptions, eyeglasses, and out-of-pocket medical expenses not covered by insurance. However, vitamins and other dietary supplements taken for general health purposes are not eligible. Purchases of over-the-counter (OTC) medicines and drugs (with the exception of insulin) are only reimbursable if accompanied by a prescription or Prescription Order Form from your medical practitioner. Below are some *examples* of eligible OTC health related expenses:

   Examples of OTC items that require a prescription or Prescription Order Form: Acid Controllers; Allergy and Sinus Medication; Antibiotic Products; Cough, Cold, and Flu Medication; Digestive Aids; Pain Relief Medication; Respiratory Treatments; Sedatives; and Stomach Remedies

   Examples of OTC items that are eligible and need no physician authorization: Bandages; Blood Pressure Kits; Contact Lenses; Contact Lens Solution; Diabetes Testing Supplies; Durable Medical Equipment; Hearing Aid Batteries; Heating Pads; Insulin; Nebulizers; and Walkers and Wheelchairs
5. **How does the Dependent Care Assistance Program (DCAP) account compare with the tax credit available on the individual Form 1040?** The circumstances that determine which option offers greater savings vary from family to family. As such, the decision to choose the tax credit or the DCAP deduction may be made on a case by case basis only. Participation in the DCAP results in an immediate savings on Federal, State, and Social Security tax, whereas the Federal credit will affect Federal Income Tax only and will be taken at year-end.
6. **How does a Cafeteria Plan, such as a Healthcare Flexible Spending Account, affect Social Security benefits?** Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs made possible by FSA participation. To compensate for this minimal reduction, you may want to consider increasing your retirement plan funding.
7. **Under what circumstances may the annual election amounts be changed?** The elections may be changed only if there is a change in family or employment status, as defined by Section 125 of the Internal Revenue Code.
8. **What is the Use-or-Lose Rule?** To avoid an account balance at year-end, be conservative when making your annual elections. Any funds left at the end of the Plan Year grace period are forfeited.
9. **Who determines the rules and regulations of Healthcare FSAs and Dependent Care Assistance Program accounts?** These accounts are regulated by the IRS. Plan administrator documentation guidelines are intended as a means to ensure eligibility of your requests for reimbursement. It is the Participant's responsibility to comply with these guidelines and to avoid duplication of requests or submission of ineligible charges. Failure to adhere to established requirements could lead to payment delays or denial of expense reimbursement. In the event of an error or omission in the course of administering the Plan on behalf of the employer, ConnectYourCare will notify and remedy the error or omission. The employer and employees agree to ConnectYourCare's procedures for making any corrections, including but not limited to payroll reduction. An error by the employer or ConnectYourCare does not constitute an assumption of liability for the amount of the error.