Lane ESD
2021-22 FSA Enrollment Form

You will be making elections for the **October 01, 2021** through **September 30, 2022** Plan Year. After completing this form, please sign, date, and **return it to your Human Resources Department on or before the end of your enrollment period.**

SECTION A: PARTICIPANT PROFILE – *Please Print Legibly*

First Name		Home Phone ( ) -	
Middle Initial		Work Phone ( ) -	
Last Name		Date of Birth (mm/dd/yyyy) / /	
Social Security Number		Gender ☐ Female ☐ Male	
Email Address		Marital Status ☐ Married ☐ Single ☐ Domestic Partner	
Address Line 1		Address Line 2	
City		Date of Hire (mm/dd/yyyy) / /	
State	Zip Code	Division (if applicable)	

Are you enrolling a Domestic Partner? ☐ No ☐ Yes (**Name:** / **SSN:**)

SECTION B: PLAN INFORMATION – *Please Print Legibly*

Healthcare – Flexible Spending Account (FSA) Out-of-pocket medical, dental, and vision expenses. Contribute up to $2,750 for the plan year (Min $0). *Important Note Regarding Registered Domestic Partnerships (RDP):* The total amount that may be contributed by an employee who has a same-sex RDP to the Federal FSA plus State FSA must be no greater than the amount that could be contributed to a Federal FSA.	☐ Yes ☐ No	Employee (Fed + State): $ _____ + RDP (State Only): $ _____ = **Total**: $ _____
Limited Healthcare – Flexible Spending Account (LMT) ***For HSA Enrollees*** – Used for dental and vision expenses only. Contribute up to $2,750 for the plan year (Min $0).	☐ Yes ☐ No	Employee (Fed + State): $ _____ + RDP (State Only): $ _____ = **Total**: $ _____
Dependent Daycare – Flexible Spending Account (DCA)* Child (covered up to 13th birthday) and/or adult daycare expenses. If married filing jointly or single – Contribute up to $5,000 for the plan year. If married filing separately – Contribute up to $2,500 for the plan year (Min $0). **IRS regulations state that a participant may only elect a maximum of $5,000 per calendar year (January thru December). If your plan runs off-calendar or if you are enrolling in a short plan year, keep this in mind when making your election(s).*	☐ Yes ☐ No	Employee (Fed + State): $ _____ + RDP (State Only): $ _____ = **Total**: $ _____

DEPENDENT INFORMATION

My Dependents:		**My Domestic Partner's Dependents (if applicable):**
Spouse Name	DOB / /	Child Name
Child Name	DOB / /	Child Name
Child Name	DOB / /	Child Name
Child Name	DOB / /	Child Name
Child Name	DOB / /	Child Name

SECTION C: PARTICIPANT AUTHORIZATION

I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amount(s) I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all acknowledgements & authorizations provided by Chard Snyder for each plan/option elected above on the back of this form.

Signature	Date / /

HR USE ONLY (FOR MID-YEAR NEW HIRES) – *Must be completed by HR Rep prior to sending to Chard Snyder*

Employee Effective Date / /	1st Contribution Date / /	Initials

PARTICIPANT ACKNOWLEDGEMENTS & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate in the plan/option.

FLEXIBLE SPENDING ACCOUNT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above) and submit my claims by the end of the run out period or the funds will be forfeited. If my plan provides a carryover, funds remaining in my FSA reimbursement account will be carried over into the new plan year up to my plan's allowed carryover maximum. Funds remaining above my plan's allowed carryover maximum will be forfeited.
- I cannot change my election once the Plan Year begins; my election(s) must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

BENEFIT CARD – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I have received, reviewed and understand the procedures of this benefit card.
- Benefit card funds are authorized only for the payment of qualified expenses as outlined in my employer's plan document.
- The benefit card may be used only for eligible expenses at the point-of-service, and I may be required to submit a claim form with receipts and/or bills to Chard Snyder to substantiate the expense.
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled.
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.
- If I use my benefit card for ineligible expenses, I will be required to pay back the amount that was not covered by my plan.
- If I do not repay amounts used for ineligible expenses, my employer and/or Chard Snyder has the right to cancel my benefit card and deduct this amount from my salary.
- These funds have not or will not be reimbursed under any other plan coverage.
- Chard Snyder will not be held responsible for processing duplicate claims that I have submitted in error.
- The benefit card may not be accepted at all merchants that accept MasterCard.
- I must check with my employer to verify the monthly fee, if any, to add to the benefit card.

I understand and agree to the terms and conditions specified on this form and authorize Chard Snyder to complete my request as indicated.

DIRECT DEPOSIT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and/or debit the same to such account.
- I will not hold Chard Snyder responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me, my employer or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.
- Chard Snyder reserves the right to collect a $25 processing fee for transaction returns and reserves the right to periodically change this fee. Chard Snyder is not responsible for any fees that may be incurred and charged to me by my financial institution.
- Direct deposit of my reimbursements shall commence within 4 (four) weeks of receipt of this form.
- My direct deposit may be terminated by any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, cancellation of direct deposit by my employer or in the event that processing fees are incurred and are unpaid for a period of 60 days.

I hereby agree to and understand the information on this form and authorize Chard Snyder to complete my request.