❑ **New Enrollment**
❑ **Change in Enrollment**

MONROE COUNTY
2023 FLEXIBLE SPENDING ACCOUNT (FSA)
ENROLLMENT FORM

Birth Date: Mo / Day / Year	**Gender:**	**Marital Status:**	**Date of Hire:** Mo / Day / Year	**Enrollment Date:** Mo / Day / Year	**Effective Date:** Mo / Day / Year
	☐ Male ☐ Female	☐ Single ☐ Married			**Payroll Use Only**

Name:	**Social Security #:**
Street:	**Email Address:**

City:	**State**	**Zip Code:**	**Work Telephone:**	**SAP ID:**

DEPENDENTS	GENDER	Name	Medical	Dependent Care	Birth Date	Social Security #
Spouse	☐ Male ☐ Female		☐			
Dependent	☐ Male ☐ Female		☐	☐		
Dependent	☐ Male ☐ Female		☐	☐		
Dependent	☐ Male ☐ Female		☐	☐		

BENEFIT ELECTION OPTIONS	PARTICIPATION	PAY PERIODS	SALARY REDUCTION AMT.
Medical/Dental/Vision/Rx **$3,050** maximum per plan year I have completed 12 full months of service in order to be eligible to participate in this Plan.	YES ☐ NO ☐	**26***	$_____ **PLAN YEAR**
Dependent Care Account **$5,000** maximum per plan year ($2,500 if married filing separately) This plan is for eligible dependent children under age 13	YES ☐ NO ☐	**26***	$_____ **PLAN YEAR**

By enrolling in the Flexible Spending Account (FSA) I understand that:

- The 2 ½ month Benefit Year Extension/Grace period provides more time for me to use the funds in my account. If I have a balance remaining in my account on December 31st, I can be reimbursed for eligible expenses incurred between January 1 and March 15th of the following plan year. Any remaining balances will be forfeited 90 days after year-end.
- Claims must be submitted within 30 days from the date of my separation from employment with Monroe County (i.e. resignation, retirement, or termination) for services incurred prior to the separation date.
- Amounts allocated to Health Care and/or Dependent Care are pre-tax expenditures. Elections may not be changed during the Plan Year except for a change in family status. Money may not be transferred between options (Health and Dependent Care).
- Dependent Care expenses will be reimbursed up to the balance funded through payroll deductions. Federal form W-10 for each dependent care provider must be on file with HEG.
- The Wex Health Payment Card is for use with my FSA, and I agree that I (and my dependents, if any) will use the debit card solely for its intended use. Documentation substantiating any and all of my purchases must be submitted upon request from Health Economics Group. If this card is misused in any way, it will be deactivated and it will remain my responsibility to reimburse the plan for all ineligible expenses. Further, I agree to read and to abide by all terms described in detail with materials received with my card. **There is a $10 fee for any additional cards and/or the replacement of lost or stolen cards that will automatically be deducted from my plan balance.**
- **The Wex Health Payment Card may NOT be used for Dental Expenses.**
- Reimbursement from my FSA will automatically be directly deposited into my bank account. I hereby authorize Health Economics Group, Inc. (HEG) to originate electronic credit transactions to my bank (or credit union or savings & loan) account indicated below and to credit the same to such account. If necessary, HEG may make deductions from my account for any payments credited to my account in error.

*** New employees: Enrollment after the beginning of the Plan Year, pay period amounts will be prorated by the length of time remaining in the plan year.**

DIRECT DEPOSIT Bank Information (Mandatory). ***Must attach a voided check (NOT A DEPOSIT SLIP) if not already on file with HEG.***

CHECK HERE IF ALREADY ON FILE WITH HEG: ☐

Bank Name:	**Routing Number:**
Account Type: Checking ☐ Savings ☐	**Account Number:**

Employee Signature: _____ **Date:** _____

Please return this enrollment to:
Human Resources, Room 210, County Office Building, 39 West Main Street, Rochester, NY 14614
e-mail: hrbenefits@monroecounty.gov