THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING COMMISSION
6611 Kenilworth Avenue, Riverdale, Maryland 20737

2018 Flexible Spending Account Enrollment Form

EMPLOYEE INFORMATION

Name	Employee ID
Day phone	Work Location

Direct Deposit Option for Reimbursement:

If you want your reimbursement checks deposited directly in your checking account, you must complete a form located on the Benefit Strategies web site and include a copy of a voided check. To change your bank account, you will need to perform the same process described above. To disenroll, call the Plan's Customer Service number and follow their directions.

Election Information: All columns must be completed for new enrollments and re-enrollments to be effective.

	Amount Per Pay Period	OR	Annual Election	Maximum Allowed
☐ Health Care Reimbursement (for Health Care expenses)	_____		_____	$2600
☐ Dependent Care Reimbursement (for day care expenses)	_____		_____	$5000

NOTE 1: In the event of a calculation discrepancy, the amount per pay period will be the amount used, and the annual election amount will be recalculated. If the recalculated amount exceeds $2,600 or $5,000, the amount per pay period will be adjusted.
NOTE 2: If you are married and filing separately, your dependent care maximum is $2,500.
NOTE 3: The pay reduction will not be effective before you have signed the form and returned it to the Health & Benefits Office. Do not send to the vendor directly. If you do, your election will not be considered valid.

ENROLLMENT/CHANGES/TERMINATIONS - Must provide reason on form and must be authorized by employer

Date of Qualifying Event: ____/____/____ Check The Qualifying Event Reason:

- ☐ Open Enrollment / New Hire
- ☐ Birth/Death of spouse or dependent
- ☐ Change in day care providers
- ☐ Loss of dependent status
- ☐ Marriage / Divorce
- ☐ Status change from full-time to part-time by employee or spouse
- ☐ Status change from part-time to full-time by employee or spouse
- ☐ Spouse's employment commenced/terminated
- ☐ Termination of Employment or Retirement
- ☐ Unpaid leave of absence by employee or spouse

I elect to participate in the Commission's Flexible Spending Account for the above indicated Plan Year. I understand that I must re-enroll each year. Only original signed forms are accepted. I also authorize the health vendors to provide claim information to the Commission's flexible spending account administrator in connection with debit card claims and administration. Proof of the qualifying event must be submitted with this form before any change can be made. Any prior plan year form will not be accepted for the current plan year. I revoke any previous election and salary reduction agreement. If I retire at the end of the calendar/plan year, I may not participate in the flexible spending account program for the following year. **Any overpayment made to me may be recovered through payroll deduction or annuity payment, if I have not reimbursed the FSA administrator within 90 days of notification of the overpayment.**

I have read and agree to the terms and conditions set forth on the reverse side of this form.

Employee Signature: _____

Date _____

HEALTH & BENEFITS ONLY	DATE	INITIALS
Received		
HRIS		
Effective Date		
Verified		

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As a participant, I understand that:

1. I cannot change or revoke this agreement at any time prior to the next plan year unless I have a change in family status as described in the Summary Plan Description. Prior to my next plan year I will be offered the opportunity to change my benefit election for the next plan year.
2. Deductions from my salary will occur for the remainder of the calendar year, unless this agreement is amended or terminated. Deductions represent the options I have selected and my take-home salary will be reduced accordingly.
3. The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my salary reduction will automatically be adjusted to reflect that change.
4. The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy compliance with the Internal Revenue Code.
5. **Only my child(ren) under the age of 13 or a child(ren) 13 years or older who is disabled is/are eligible for dependent care reimbursement. If a child turns 13 during the plan year only expenses incurred before he or she turned 13 will be covered**. **You may change election amount within 45 days of child reaching age 13.**
6. The amount of my compensation reduction will be credited to the appropriate reimbursement account on my employer's books for payment of eligible expenses incurred within the plan year.
7. I will have until March 31st following the end of the plan year or 90 days following my termination of employment to submit receipts for services received during the plan year. If I terminate, all expenses must be incurred prior to my termination, unless I elect to continue after-tax payments to the plan after my termination.
8. Reimbursement will be available only for qualifying expenses. I agree to notify the Commission if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Commission for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
9. I agree on demand to indemnify and reimburse the Commission for any non-qualifying or non-eligible expenses reimbursed or for any overpayment made. If retired I authorize the Commission to request deduction from my annuity check.
10. If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount in accordance with IRS regulation.
11. If I am married, to be eligible for the dependent care FSA, I affirm that my spouse is working, going to school full time, or is incapable of self care. From the point in time that this changes, I understand I will be ineligible to further participate in the dependent care FSA.
12. This authorization is binding for the entire plan year, unless I terminate my employment or experience an eligible family status change. If I incur an eligible change in family status, I understand that I must file a change form within 45 days.
13. If my spouse elects to participate in his/her employer plan, I/we are responsible for making sure we do not exceed the IRS limit of $5,000 per family or $2,500 per person for dependent care or health care. If we do, my spouse is required to make a change in his/her election status plan. No change will be made in the M-NCPPC plan.
14. My reimbursement may take 7-10 business days to be processed. I will allow 7 business days for direct deposit reimbursement and 10 business days for mail reimbursement.
15. I have read the Commission's information on this plan in the Employee Benefits Handbook including the definition of a dependent.
16. **The FSA administrator nor M-NCPPC shall have any liability for any erroneous payment arising out of my failure to notify the FSA administrator of a lost or stolen spending account card or my termination as a participant in the FSA Plan**.

The pay reduction will not be effective for any pay period that begins before you have signed this form and returned it to the Health & Benefits Office

RETURN THIS FORM TO: **M-NCPPC**
Health & Benefits Office Suite 404
6611 Kenilworth Avenue
Riverdale, MD 20737

OR Email to Benefits@mncppc.org
Fax to 301-454-1687

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