



## 2021 FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

(Return this form to Terri Heintz, BOE Central Office by 12/07/20)

<b>Simsbury Public Schools</b>		12 Month Plan Year Short Plan Year	<b>To be completed by Employer</b>	
Employee's First Middle Last Name		Employee Effective Date for Plan: <b>01/01/2021</b>		For 25% Concentration Test - Is this employee considered a: Key Employee Yes No Highly Compensated Yes No
Employee's Address: Street, City, State, Zip		Date of first Payroll Deduction: <b>01/14/2021</b>		Employee Social Security Number
Employee Birth Date _____ Mo / Day / Year		Gender Male Female	Marital Status Single Married	
<b>(Required)</b> Employee E-mail Address for Plan notices and communications		<b>Complete for additional debit card(s):</b> Spouse/Dependent(18-26 years of age) Name Social Security Number Date of Birth		
You may access your FSA Account online at: <a href="https://www.mywealtheonline.com/stirlingbenefits/">https://www.mywealtheonline.com/stirlingbenefits/</a> or download our Mobile app – Search Stirling Benefits		Spouse and dependent debit cards will automatically have access to FSA Funds. Please Note: If you previously requested additional debit cards for your spouse or dependents, their debit card will automatically have access to new Plan Year elected funds. Please call our office to communicate changes.		

Employer Plan Effective Date: **January 1, 2021** - Eligible Expenses incurred: **January 1, 2021 – March 15, 2022** must be submitted to the Stirling Benefits office no later than: **March 31, 2022**.

**Employees who elect to participate in the program will pay an Annual Fee of \$60.00 (\$5.00 per month.) Only (1) Annual Fee will be charged for employees enrolled in multiple accounts.**

**Health Care Account (HCFA):** (Minimum \$100 / Maximum - \$2,750)

Participation in the HC FSA account will impact your eligibility to a Health Savings Account. If you or your employer on your behalf, actively contribute to an HSA account, or your spouse contributes to an HSA, you may not participate in the FSA Health Care Account.

Annual Election	+ \$60 Annual Fee	Total Annual Election	Divided By # of Pays	HCFA Deduction Per Pay
_____	\$60.00	_____	20 Pays	_____

**Limited Purpose (LPF):** (Minimum \$100 / Maximum - \$2,750)

For employees that are contributing to an HSA Account – the LPF account is for Dental and Vision Expenses Only.

Annual Election	+ \$60 Annual Fee	Total Annual Election	Divided By # of Pays	LPF Deduction Per Pay
_____	\$60.00	_____	20 Pays	_____

**Dependent Care Account (DCA):** (Minimum \$100 / Maximum - \$5,000)

For employees needing Child (Dependent) Day Care.

Annual Election	+ \$60 Annual Fee	Total Annual Election	Divided By # of Pays	DCA Deduction Per Pay
_____	\$60.00	_____	20 Pays	_____

**YES, I want to enroll.** The IRS regulation states these conditions: 1.) Any expenses you incur must be within the plan year. 2.) Any expenses you incur must not be covered by any other source such as insurance. 3.) You must provide proper documentation in order to receive payment. 4.) You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. **NOTE:** Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice.

Signature: x \_\_\_\_\_ Date: \_\_\_\_\_

Accepted and Agreed to by Simsbury BOE Authorized Representative

By \_\_\_\_\_ Date \_\_\_\_\_