FBMC BENEFITS MANAGEMENT
Attention Mailslot 37
PO BOX 1878
TALLAHASSEE, FL 32302-1878

2024 STATE OF WEST VIRGINIA
KANAWHA COUNTY BOARD OF EDUCATION
ENROLLMENT FORM

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

July 1, 2023 - June 30, 2024

Please make a copy for your records, and submit your completed form to your employer.

LAST NAME	FIRST NAME	MI	SS#

HOME ADDRESS [STREET]	CITY	STATE	ZIP

DAYTIME PHONE	HOME PHONE	DATE OF HIRE	DATE OF BIRTH	ANNUAL SALARY

E-MAIL ADDRESS:

ENROLLMENT STATUS: ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ NEW HIRE	EFFECTIVE DATE

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below. Complete the worksheets provided in your ***2024 Mountaineer Flexible Benefits Enrollment Guide*** before deciding on the amount. If you have questions, consult your ***2024 Mountaineer Flexible Benefits Enrollment Guide***, or your Benefit Coordinator.

In Box 1, indicate the dollar amount you elect to contribute for the 2024 Plan Year.
In Box 2, indicate the number of regular payroll checks with deductions you expect to receive during the 2024 Plan Year.
In Box 3, indicate the deduction amount per paycheck. (**Note:** if Box 2 times Box 3 does not equal Box #1 exactly, the amount in Box 3 may be changed slightly by FBMC due to rounding).

By signing this form you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, planned retirement or any other anticipated leave.

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	MOUNTAINEER FLEXIBLE BENEFITS	Box 3 COST PER PAY PERIOD
☐	☐	☐	☐	**HEALTH CARE FLEXIBLE SPENDING ACCOUNT** ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2024. Receive reimbursement for uninsured eligible medical expenses incurred by you, your family members, or both. [Annual minimum allowable contribution is $150; maximum is $3,050.] **Box 1** Total Plan Year Dollar Amount from your Worksheet _____ ÷ **Box 2** Number of Pay Periods _____ =	
☐	☐	☐	☐	**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT** ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2024. ☐ Married, Filing Separately ☐ Married, Filing Jointly ☐ Single, Head Of Household **Box 1** Total Plan Year Dollar Amount from your Worksheet _____ ÷ **Box 2** Number of Pay Periods _____ =	
				TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD	

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal and state income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with my employer within 30 days of the event.
- I understand and agree that my employer and FBMC Benefits Management, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA 3) I will not seek reimbursement through any additional source and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED

BENEFIT COORDINATOR	DATE SIGNED	TIME SIGNED

SUBMIT YOUR COMPLETED FORM TO KANAWHA BOARD OF EDUCATION 200 ELIZABETH STREET CHARLESTON, WV 25311-2119, NO LATER THAN MAY 15, 2023.