Paychex Use Only
Client BIS ID _____

PAYCHEX

Enrollment Form
Paychex Benefit Account Flexible Spending Account

SECTION 1 - EMPLOYEE INFORMATION (print)

Office/Client Number 0400-2091 or 0400-2090 _____

Company Name: Episcopal Diocese of California_____ Employee Telephone Number (___) _____ - _____

Employee Name _____ Social Security Number _____

Address_____ City _____ State _____ ZIP Code_____

Email Address _____

SECTION 2 - ENROLLMENT OPTIONS (select one)

☐ **New Enrollment or Annual Enrollment Changes**
Date of Hire _____ / _____ / _____

Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met.

Annual enrollment changes will be effective on the first payroll following January 1.

☐ **Change In Status**
Date of Event _____ / _____ / _____

Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to the Employer within 30 days of the event.

☐ Dependent care cost provider changes
☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements
☐ Birth/Death of spouse or dependent, adoption or placement for adoption
☐ Spouse's employment commenced/terminated
☐ Status change from full-time to part-time or vice versa by employee or spouse*
☐ Eligibility or Ineligibility of Medicare/Medicaid
☐ Change from salaried to hourly or vice versa*
☐ Marriage/Divorce/Legal Separation
☐ Unpaid leave of absence by employee or spouse
☐ Return from unpaid leave of absence by employee or spouse

* These changes are allowable only if eligibility is affected.

SECTION 3 - ENROLLMENT ELECTION

To calculate your per-pay-period deduction, divide your annual amount by the number of pay periods remaining in the plan year.
In accordance with IRS regulations, Employee contributions to the medical FSA cannot exceed the lesser of the company's plan maximum or $2,600.00. Employers may contribute an additional amount which will be added to the Employee's contribution amount to equal the total annual election amount.

☐ Annual Medical/Dental/Vision Election $_____ (**Medical FSA**)
Cannot Exceed Company Maximum $2,600.00

☐ Annual Dependent Care Election $ _____ (**DCA**)
Maximum $5,000.00
DCA is issued for custodial care of a dependent, not for medical expenses of a dependent.

☐ Discontinue my Enrollment in Medical/Dental/Vision Care

☐ Discontinue my Enrollment in Dependent Care

To discontinue enrollment, a change in status reason must be selected.

Notes: If you are enrolled only in DCA, a debit card will not be issued. Dependent information is required to submit claims for services incurred by your dependent. To update this information please visit https://benefits.paychex.com, click **Add Dependent** under the Profile section of the Paychex Benefit Account page.

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year 01 / 01 / 18 . Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. I cannot change or revoke this election at any date prior to the next plan year unless I experience a change in status (also referred to as a qualifying event). If, during my next enrollment period, I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election as set forth in this election form for the next plan year. As a participant, I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

Reduction of Pay

- I understand that my pay will be reduced each pay period by the amount of my required contribution for the benefit option(s) I have elected until this agreement is amended or terminated. The reduction in my pay under this agreement will be in addition to any reductions under other agreements or benefit plans.
- I understand that my pay reduction will be automatically adjusted if my required contributions change while this agreement is in effect and that the plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.

Reimbursements

- I understand that my Employer will hold my contributions for payment of eligible expenses incurred within the Plan Year and that reimbursement will be available only for qualifying expenses.
- I agree to notify my Employer if I believe that any expense for which I have received reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer for any liability Employer may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- I understand that I will have a closeout period after the end of the plan year during which I can submit eligible expenses incurred during the plan year (and grace period if applicable). I understand that I will forfeit any remaining balances, including those in excess of any allowable carryover amount; I have at the end of the closeout period for which I have no eligible expenses to submit.

FSA with an HSA

- If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.

Employee Signature _____ Date _____ / _____ / _____

Account Information is available at https://benefits.paychex.com or on the FSA Information Line by dialing 877-244-1771.
MAIL or FAX to Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: 585-389-7349

SUBMIT ENROLLMENT FORM TO DIOCESE BEFORE 1st PAYDAY by fax: 415-673-4863 or email: sarahc@diocal.org