FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

DOUGLAS COUNTY SECTION 125 FLEX BENEFIT PLAN

RESET FORM

RETURN COMPLETED FORM TO HUMAN RESOURCES

For Plan Summary and other information visit Human Resources Employee Benefit Page

Print Name: _____

NEW and/or RE-ENROLLMENT: Employees must re-enroll every year in the Medical Flexible Spending Account and/or Dependent Care Flexible Spending Account. A fee of $1.00 (per plan) is charged each pay period (24 pay periods) through payroll deduction for administrative expenses.

Medical FSA**

Maximum contribution limit: $3,200.00

$_____ Medical FSA Employee ANNUAL deduction amount;

Dependent Care FSA**

Maximum contribution limit: $5000.00

$_____ Dependent Care FSA Employee ANNUAL deduction amount

$_____ Total FSA accounts employee ANNUAL deduction amount

****Estimate expenses carefully, as you will forfeit any amount left in your account(s) at the end of the plan year.**

I understand that I cannot change or revoke this benefit election form prior to the open enrollment for the next plan year unless I have a qualifying family status change (i.e. marriage, divorce, death of spouse or child, birth or adoption of a child or change of employment of spouse). NOTE: Changes based upon a qualifying event must be made within 30 days of the qualifying event. If required contributions for the elected benefits are increased or decreased while this agreement remains in effect, pay changes will automatically be adjusted.

The Plan Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this Agreement in accordance with the Flexible Benefits Plan if it is advisable in order to satisfy provisions of the Section 125 Internal Revenue Code.

I agree to pay a fee of $1.00 (per plan) each pay period (24 pay periods) for administrative services to participate in the Medical Reimbursement Account and/or Dependent Care Reimbursement Account. I certify the above information to be true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Spending deduction(s) will be in effect for the entire plan year and cannot be revoked unless I experience a qualifying event.

Signature: _____ Date: _____