SharedFunding
A new approach to health care.

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Berkshire Local Schools
Flexible Spending Account Plan
2022 FSA Election Form
Plan Year Start 1/1/2022 end 12/31/2022

Deductions begin with the first payroll of 2022 for all deductions.
Expense Deadline: You must incur all eligible expenses by 03/15/2023.
Claims Deadline: You must submit all reimbursement requests by 04/30/2023.

I. Employee Information

Employee Name: _____

Address: _____

Email: _____

II. Dependent Care Reimbursement Account

This pays for daycare expenses for a dependent child, adult or other, so that you may work. Eligible services include nursery school, nanny, before/after school care through age 12, daycare for disabled adult or child, elder daycare for parents or dependent, day camp through age 12. You may elect to deposit up to $5,000 a year. However, if you are married and file your taxes separately, you are limited to $2,500 a year.

Enter dollar amount to deposit per pay: $_____ or $_____annually

III. Medical Care Reimbursement Plan

This plan is a fund that will help you to save money on expenses that normally would not be paid by your traditional health insurance plan and can be utilized to offset your out of pocket medical, dental, vision and Rx expenses (as well as other qualified out of pocket health care expenses.) Expenses are paid with pre-tax dollars. You may elect up to $2,850 for the period of 1/1/2022 through 12/31/2022.

Enter dollar amount to deposit per pay: $_____or $_____annually

Important – Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections (selected above) set forth above and that qualified expenses will be paid for on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day each plan year, I will be offered the opportunity to change my benefit election for the upcoming year. I acknowledge that I have received, read, and understand the account description. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer for any expenses not repaid by me. I authorize my employer to deduct the amount from my paycheck. If permitted by state law.

_____ _____

Employee Signature Date

See page 2 for account description) Return completed form to your employer

ACCOUNT DESCRIPTION

This agreement will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required benefit contributions increase or decrease.

Salary contributed into one choice cannot be transferred and used for expenses in any other choice.

* A new agreement form must be completed each Plan Year. If a new agreement form is not completed prior to the end of the plan year, reimbursement accounts will cancel.

Social Security (FICA) tax is not being withheld on the amount of the salary reduction under this Agreement. The amount of salary reductions may not be claimed on your or your spouse's income tax return.

This agreement can only be changed or revoked during the plan year if there is a qualifying change in family status or if you are no longer eligible to participate.

**** If Employment terminates, member must submit eligible expenses within 60 days of termination date. All eligible expenses must be incurred prior to termination date. Once the 60-day period has ended, any unused funds will be forfeited ****

Your Employer has chosen the following option for unused FSA funds:

* Grace period of two-and-a-half months to incur new expenses using prior-year FSA funds.

* You must incur all eligible expenses by 3/15/2023.

* You must submit all eligible 2022 claims by 4/30/2023.

* At the end of the grace period, all unspent funds will be forfeited.

* The annual contribution limit is not affected by the grace period.

* Recurring expenses or expenses from service dates spanning two plan years cannot be submitted as one claim. Recurring expenses must be submitted and reimbursed as they occur.

Expenses are submitted to Barrett Benefits Group via mail, email, or fax and must include the following information: Provider name and address. Patient/Dependent name. Date of service. Description of services. Amount charged.

Barrett Benefits Group, Inc.
Fax (866) 539-5643
Sharefund@bbginc.net
593 Broadway Ave.
Cleveland, OH 44146