WageWorks Flexible Spending Account Election Form

October 1, 2023 through September 30, 2024 Plan Year

www.wageworks.com

Which type of Healthcare FSA do you qualify for? (choose one)

☐ ***Limited Purpose FSA – For Dental/Vision Only.*** Choose this option if you are **(a)** ***covered under a Health Savings Account***, either your own or as a dependent on a spouse/parent HSA ***OR*** **(b)** ***a part time employee*** eligible for dental/vision insurance. This type of FSA is **limited to qualifying dental and vision expenses only (no medical)** and is compatible with an HSA.

☐ ***Regular Healthcare FSA.*** Choose this option if you are NOT covered under any HSA-Compatible High Deductible Health Plan, and if you are eligible for the district's medical insurance. You cannot be covered as a dependent on another individual's Health Savings Account. This type of FSA can be used for qualifying medical, dental, and vision expenses.

Important Note: The IRS does not allow a person to be covered under both a Flexible Spending Account and a Health Savings Account for medical expenses. If you are covered under a Health Savings Account, even as a dependent on someone else's account, you must choose the HSA-Compatible Limited Purpose FSA.

For more detailed information about IRS eligibility requirements for Flexible Spending Accounts, see IRS Publication 969. For information about eligible expenses, see IRS Publication 502. You will also find lots of helpful information and FAQ's at: **https://www.healthequity.com/learn/flexible-spending-account**

WAGEWORKS ACCOUNT ENROLLMENT INFORMATION:

Employee Name:_____

Physical Address (Required):_____

Mailing Address (if different):_____

City:_____ State:_____ Zip:_____

Email:_____

SSN (last 4 digits):_____ Phone Number:_____

Date of Birth:_____ Date of Hire (if known):_____

Healthcare FSA Contribution Elections:

☐ **I elect to receive the district's contribution to the Flexible Spending Account**

☐ **In addition, I elect to make my own pre-tax contributions to the FSA *(optional)***

District Contributions:	$41.50 per month x 12 months	$ 498.00 (annual)
My Contributions: **($2850 Max. allowed)**	$_____ per month x ____ paychecks	$_____ (annual)

Dependent Care FSA Contribution Elections:

☐ **I elect to make pre-tax contributions to the Dependent Care FSA *(optional)***

My Contributions: **($5000 Max. allowed)**	$_____ per month x ____ paychecks **(please sign on reverse side)**	$_____ (annual)

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects me or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Flexible Spending Account may be limited.

I understand that I can only be reimbursed from the plan for eligible expenses incurred while I am an active employee. I cannot be reimbursed for expenses incurred after my employment terminates.

I understand this is a use-it-or-lose-it account. Funds not used by the end of the plan year, or before my employment termination date, will be forfeited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

I understand that if I am enrolled in the Limited Purpose FSA either because I am a part-time employee ***OR*** because I am covered under another person's HSA account, my account cannot be used for medical expenses. This type of account is limited to dental and vision expenses only.

_____ _____

Employee Signature Date