BlueCross BlueShield of Vermont
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FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Complete this two part form and return to your employer.

Group Information

Group Name: _Washington Central Unified Union School District Further Group Number: _021342__

Location Name (if applicable):_____

Employee Information

SSN#: _____ Primary Phone: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address:_____ Date of Birth:_____ / _____ / _____

Account Information

Medical Flexible Spending Account:

Plan year maximum: __$3,300_____ (determined by employer, not to exceed IRS maximum of $3,300)

Effective Date: January 1, 2025 for Open Enrollment **If New Hire:** _____

☐ I want to contribute a total of $ _____ during this plan year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Are you or your spouse actively contributing to a Health Savings Account?

☐ No

☐ Yes: Your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met. Contact BCBSVT to remove the limit when your deductible is met.

Dependent Care Flexible Spending Account:

IRS Maximum: $5,000 ($2,500 if married but filing separate tax returns)

Effective Date: _____ **(To be provided by Group Contact)**

☐ I want to contribute a total of $_____ during this plan year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Signature

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year may be forfeited.

_____ _____

Signature Date

Employees: Complete and return this form to your employer.

Employers: Save time by entering this information online at least 30 days prior to your plan start date. Sign into Online Group Service Center at mymoneybcbsvt-group.hellofurther.com.

Other Terms and Conditions Statement

Qualifying Event (change in circumstances)

I cannot change or revoke any of my elections or the benefit payroll deduction at any time during the plan year unless I have a qualifying event or change in circumstances, or my employment terminates:

- ✓ A qualifying event includes: marriage; divorce; annulment; death of a spouse or dependent, birth; adoption or placement for adoption of a child; change of employment status or that of my spouse or dependent; my or my spouse's or dependent's change in worksite; change in dependent care cost due to a change in provider or fees (fees not applicable if the care provider is a relative); my spouse's or dependent's change in coverage under their employer's Flexible Benefits Plan or other qualified my or my spouse's or dependent's change in eligibility for Medicare or Medicaid; or such other events as the Plan Administrator determines will permit a change or revocation of an election.
- ✓ Termination of employment will terminate my FSA and/or DCAP election at the end of the same month of the termination. The balance in the account will be forfeited to WCUUSD.

Flexible Spending Arrangement (FSA)

The amount of my benefit payroll deduction for each pay period during the year will be credited to reimbursement accounts and such amount will be paid on my behalf or I will be reimbursed for the applicable expenses incurred during the plan year. At the end of the plan year, should my annual benefit payroll deductions exceed my actual annual expenses the excess will be forfeited and will not be paid to me in cash or used to provide benefits in a later plan year **with the exception of $660** in medical spending which will roll over to the next plan year of 2026. If seeking reimbursement for expenses incurred on or before December 31st they must be submitted by March 31st.

Dependent Care Assistance Plan (DCAP)

These funds will be available only for *"qualifying dependent care expenses,"* as described in the Internal Revenue Code Section 129, the plan document and the Summary Plan Description. I agree to notify WCUUSD if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I agree to provide the Plan Administrator with the name, address and the taxpayer identification number of my dependent care service provider (if applicable). I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance plan. I have received the Summary Plan Description for this Plan. End of Plan Year claims for expenses incurred on or before December 31st must be submitted by April 15th.

I have read and understand the above "Other Terms and Conditions Statement" before signing below. I certify that I wish to participate in the plan and elect to have the total amount stated deducted from my paychecks. The Plan Administrator may reduce or cancel my benefit payroll deduction or otherwise modify this agreement in the event they believe it advisable in order to satisfy certain provisions of the Internal Revenue Code. I understand that this will lower my taxable wages and consequently my social security base amount. Payroll deductions are pretax under Sections 105 and 125 of the Plan; therefore, the expenses paid with said funds may not be itemized and deducted again when I file my annual income taxes. Should WCUUSD incur a liability for failure to withhold federal, state, local or FICA taxes due to a fraudulent act committed by me, I will indemnify WCUUSD the liability demand.

_____ _____

Signed Dated