Flexible Spending Account Enrollment Form

Ameriflex

Please Note: *this enrollment form is for* ***Employer files only****. Do* ***not*** *submit to Ameriflex.*

Company Name: ONEIDA-HERKIMER-MADISON BOCES **Location:** OHM BOCES

Employee Name:

Member Social Security #:

Employee Email Address:

Home Address:

City: State: Zip:

Telephone: Plan Year 01/01/2026 through 12/31/2026

Date of Birth: Effective Date: 01/01/2026

The company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay non-reimbursable medical, dependent care, and/or commuter expenses (if any) with after tax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

$ ANNUAL Contribution

DEPENDENT CARE SPENDING ACCOUNT (DCA)

$ ANNUAL Contribution

I UNDERSTAND THAT:

(1) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

(2) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election). Note: This does not apply to Commuter Reimbursement Accounts.

(3) The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

By signing this form I agree to the terms and procedures listed herein.

Employee Signature **Date**

RETURN FORM BY:

Email: mmanoiero@oneida-boces.org

Interoffice Mail or US Postal Service

OHM BOCES, ATTN: Margherita Manoiero

Box 70

New Hartford, NY 13413.0070