Employer Use Only

Re-enrollment __ New __ Change __

Effective Date (D.O.H) _____

1st Deduction Date _____

Begin P/P# _____

Payroll Mode W B S M Q

Division Code

COUNTY OF SANTA CRUZ
FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

2023 PLAN YEAR ENROLLMENT FORM
~Annual Enrollment Required~

I elect to participate in the County of Santa Cruz Health Care Flexible Spending Account Program (FSA) for Plan Year 2023. I authorize the annual amount of $_____ ($2,800 annual maximum, $280 minimum) to be withheld in 26 equal installments of $_____ from each paycheck, beginning in Pay Period One of 2023 and continuing throughout the plan year for the purpose of funding my FSA account. If I am hired after the first pay period of 2023 and elect to participate, the salary deduction will be effective the first full pay period after my hired date and will remain in effect through the end of the plan year.

I understand that:

- A new enrollment form is required for each plan year. A plan year is defined as January 1 through December 31; however, in accordance with IRS Section 125, the County allows the Plan Year to be extended 2½ months from 1/1/24 through 3/15/24. I understand that I must submit claims and receipts for reimbursement of eligible expenses NO LATER THAN 3/31/24. **Funds remaining after 3/15/24 will not be refunded.**
- If I do not complete and return an enrollment form during the Open Enrollment period (9/19/22-10/14/22), I will have forfeited the opportunity to participate in this program for the 2023 Plan Year.
- Under the Code of Federal Regulations (CFR) Section 1.125.4 – *Permitted Election Changes:* if a qualifying event exists, the Internal Revenue Service (IRS) allows employees to revoke or make election changes to their plan outside of an Open Enrollment period.
- Domestic Partner expenses are only covered if my partner is claimed as a dependent on my tax return.

I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested. When using the PayFlex Debit Card, I agree to use the card for eligible expenses only and retain all itemized receipts/statements.

Employee Signature: _____Date (mm/dd/yyyy): _____

Employee Name (Print): _____Date of Birth: _____/_____ /____
month day year

Employee Payroll #: _____Primary Phone: _____
Employee Payroll# – this will be your ID# for FSA participation.

Mailing Address: _____
(Number and Street Address) (City) (State) (Zip Code)

RETURN THIS COMPLETED FORM TO THE PERSONNEL DEPARTMENT, BENEFITS OFFICE
701 OCEAN ST., ROOM 510, SANTA CRUZ, CA 95060

For questions email the Benefits Office at: benefits.questions@santacruzcounty.us, call the Benefits Hotline at (831) 454-2241 or visit the Benefits Webpage at: http://www.santacruzcounty.us/benefits.