County of Santa Cruz
Flexible Spending Account (FSA) Program

ANNUAL ENROLLMENT REQUIRED

Employer Use Only
Re-enrollment __ New __ Change __
Effective Date (D.O.H) _____
1st Deduction Date _____
Begin PP# _____
Payroll Mode: Bi-weekly
Division Code_____

I am electing to participate in the County of Santa Cruz Flexible Spending Account Program. I understand that this salary deduction will be effective beginning Pay Period 1 of calendar year 2024. For those hired after Pay Period 1, this salary deduction will be effective the first full pay period after form submission. It will remain in effect until the last pay period of calendar year 2024. I must re-enroll each calendar year in which I wish to participate. Note: Your full annual contribution is available to use at the start of the program year to pay for eligible health care expenses.

I authorize to have the following contribution deducted from my salary to fund my FSA account during the 2024 calendar year. ($3,050 annual maximum, $305 annual minimum)

Contribution per Pay Period		Number of eligible Pay Periods		Annual Contribution (This amount cannot exceed $3,050)
$_____	**X**	_____	**=**	$_____

I understand that:

- If I do not complete and return the enrollment form during the Open Enrollment period (9/18/23-10/13/23) or new hire enrollment period, I will have forfeited the opportunity to participate in this benefit for the 2024 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.
- The Plan Year is January 1 through December 31; however, in accordance with IRS Section 125, the County allows the Plan Year to be extended 2½ months. Therefore, expenses incurred from 1/1/25 through 3/15/25 can also be claimed. Funds remaining after 3/15/25 will not be refunded.
- I understand that I must submit claims and receipts for reimbursement of eligible expenses NO LATER THAN 3/31/25.
- Domestic Partner expenses are only covered if my partner is claimed as a dependent on my federal tax return.

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

Employee Name(print): _____ Date of Birth: _____

Mailing Address: _____

Employee Signature: _____ Primary Phone: _____

Employee Payroll # (exclude leading zeros): _____ Note: This is your ID # for FSA participation.

Forms can be submitted via DocuSign, by email to benefits.questions@santacruzcountyca.gov, by USPS mail or in person to the Personnel Office (Benefits) at 701 Ocean St. Room 510, Santa Cruz CA, 95060.

For questions contact the Benefits Team at the Benefits Hotline (831) 454–2241 or by email to benefits.questions@santacruzcountyca.gov