County of Santa Cruz

Flexible Spending Account (FSA) Program

2025 Plan Year Enrollment Form

ANNUAL ENROLLMENT REQUIRED

I am electing to participate in the County of Santa Cruz Flexible Spending Account (FSA) Program. I understand that this salary deduction will be effective beginning pay period one of Calendar Year 2025. If I am hired after pay period one, this salary deduction will be effective the first full pay period after submission of the completed form. It will remain in effect until the last pay period of Calendar Year 2025. 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 your enrollment to pay for eligible health care expenses.

I authorize the following deduction from my salary to fund my FSA account during the 2025 calendar year. ($3,300 annual maximum, $330 annual minimum)

Contribution per Pay Period		Number of eligible Pay Periods		Annual Contribution (This amount cannot exceed $3,300)
$_____	**X**	_____	**=**	$_____

I understand that:

- If I do not complete and return the enrollment form during the Open Enrollment period
- (9/16/24-10/11/24) or new hire enrollment period, I will have forfeited the opportunity
- to participate in this benefit for the 2025 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 1/1/26 through 3/15/26 can also be claimed.
- I understand that I must submit claims and receipts for reimbursement of eligible expenses NO LATER THAN 3/31/26. Funds remaining after 3/31/26 will be forfeited.
- 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 eligibility requirements and I agree to provide documentation when requested. I agree to use the debit card for eligible expenses only and retain all itemized receipts and statements.

Employee Name (print):_____Phone #:_____

Mailing Address:_____City:_____State:_____Zip:_____

Employee Signature:_____Date:_____

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

This form can be submitted via DocuSign on the Benefits Webpage www.santacruzcountyca.gov/benefits,
by email benefits.questions@santacruzcountyca.gov,
by USPS mail or in person to the Human Resources Department, Benefits Unit, 701 Ocean St., Suite 510, Santa Cruz, CA 95060.
If you have questions, contact the Benefits Team at the Benefits Hotline (831) 454–2241 or by email benefits.questions@santacruzcountyca.gov

OFFICE USE ONLY

____Re-enrollment ____New ____Change

Eff. Date or D.O.H_____

1st Deduction Date_____

Begin PP#_____Div. Code_____