BPC
a WEX™ company

Flexible Spending Accounts Enrollment Form

CHAMPAIGN COUNTY: Plan Year January 1 – December 31, 2024

EMPLOYEE INFORMATION

Full Name: _____ SS # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Date of Birth: _____

❑ **Please check box if you have had an address change since last plan year.**

ENROLLMENT TYPE

❑ Open Enrollment

❑ Qualifying Event/Status Change (please include a completed Status Change Form)

Complete only if eligibility is ***AFTER*** **Jan**1 Open Enrollment period:

❑ New Hire

Eligibility Date _____ First Payroll Date _____

PAYROLL FREQUENCY

❑ Weekly (52) ❑ Bi-Weekly (26, 24) ❑ Semi-Monthly (24) ❑ Monthly (12) ❑ Other

ELECTION AMOUNT

By my signature below, I authorize my Employer to make salary reduction contributions on my behalf to the following Flexible Spending Account(s) for the Plan year:

	Per Pay Period	*Annual Election*	
Dependent Care Account (DCA) $5,000 max per family or $2,500 per spouse when married and filing separate tax returns (per IRS)	$_____	$_____	❑ Decline Coverage
Health Flexible Spending (FSA) $ 3,200/year maximum	_____	$_____	❑ Decline Coverage

** Will you or your spouse open or be contributing to an HSA during the plan year?

☐ No, I do not have an HSA ☐ Yes, I do have an HSA

DIRECT DEPOSIT INFORMATION

Save time and hassle by signing to have BPC-issued reimbursements deposited directly into the account of your choice. If you already have reimbursements issued this way, you do not need to sign up again.

ACCOUNT INFORMATION:

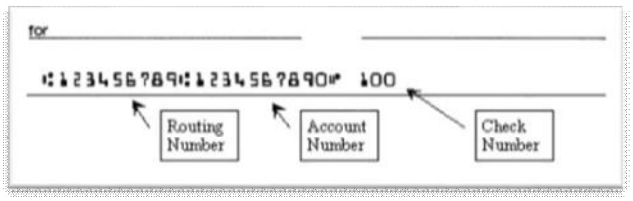
DEPOSITORY (BANK) NAME_____

CITY _____ STATE _____ ZIP _____

ROUTING NUMBER _____ ACCOUNT NUMBER _____

DEPOSITORY ACCOUNT TYPE:

❑ **CHECKING** ❑ **SAVINGS**



I acknowledge I have received and understand the terms and conditions.

_____ _____

Signature of Employee Date

PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT

TERMS AND CONDITIONS

PLEASE READ CAREFULLY: I understand that *premiums for applicable group health, dental, vision, or group term life, etc. will automatically be deducted on a pre-tax basis unless I sign the attached separate waiver form. A separate enrollment form must be completed for each insurance benefit.*

- I have received the Summary Plan Description (SPD). It is my responsibility to read and refer to the SPD for complete rules, regulations and restrictions and seek out my benefits administrator and/or BPC for questions or clarifications.
- I understand that the election(s) above will reduce my salary or wages on a pre-tax basis, and that the funds are available only for qualified expenses incurred during the course of the plan year. I cannot use the funds set aside for expenses incurred prior to the start of the plan year, or – other than limited exceptions for grace period and rollover provisions – for expenses incurred after the end of the plan year. An expense is considered "incurred" when the service giving rise the expense actually occurs – not when the expense is billed or paid.
- The election(s) above for any one Flexible Spending Account cannot be transferred to another Flexible Spending Account and that any amounts remaining in my account(s) after the run-out period and any applicable roll-over or grace period, will be forfeited.
- I will not be permitted to change the election(s) above during the Plan Year, except as explicitly allowed under the terms of the SPD. Events that may allow such changes include: marriage, divorce, increase or decrease in number of dependents, or – for the Dependent Care Account – a change in provider. I understand that any change requested must be consistent with the change in circumstances that lead to such request and that the change will generally be effective on a prospective basis only from the point requested.
- If I should terminate employment I will cease use of any applicable debit card linked to the accounts above. I will be eligible to submit claims for health and child/dependent care reimbursement until the last day of the claim filing period, as defined in the SPD. Health claims must be incurred prior to date of termination.
- I certify that all expenses for which I will request reimbursement for under these reimbursement accounts are valid expenses under the Plan and the Internal Revenue Code. I also certify that they are not reimbursable under another plan or source and may not be claimed on any federal income tax deduction or credit. If I have inadvertently received payment for an ineligible expense, I agree to provide repayment to the plan.
- I acknowledge that my participation in the Health Flexible Spending Account, except for certain limited-purpose Health FSA's, may disqualify myself and/or my spouse from opening or contributing to a Health Savings Account (HSA) for the duration of the FSA plan year.
- I understand that generally a Qualifying Individual for Dependent Care Expenses must be less than 13-years-old, or be incapable of self-care, and must share my same principal abode for more than half the year. Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent even when the noncustodial parent is entitled to claim the dependency exemption for the child.
- I hereby authorize BPC, Inc. to initiate credit entries for my Flexible Spending Accounts, Health Reimbursement Arrangements and/or Transportation and Parking accounts to the bank account indicated above and the depository named above, hereinafter called DEPOSITORY. If any credit entries are made in error, this authorization shall allow BPC to initiate corrective debits against the depository account.
- The authority for direct deposit is to remain in full force and effect until BPC has received written notification from me of its termination in such time and in such manner as to afford BPC and DEPOSITORY a reasonable opportunity to act on it.

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