

Flexible Benefit Plan Enrollment Form

July 1, 2021 PLAN YEAR
Administered by BASIC pacific

EMPLOYER: Roman Catholic Bishop - Stockton

PLAN YEAR ENDING: June 30, 2022

1	Employee Information - Please print clearly				
	FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER		
	MAILING ADDRESS		CITY	STATE	ZIP CODE
	DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS (optional)		
2	Make Your Elections - Enter your election for each account.				
	<u>Medical FSA</u> <input type="checkbox"/> I elect to participate in the Medical FSA. The amount I elect for the PLAN YEAR is (min. \$250 / max: \$2,750): <div style="text-align: center;">\$ _____ / Plan Year</div> <p>Your annual election will be deducted from your pay in equal installments throughout the plan year.</p> <input type="checkbox"/> I DECLINE to participate in the Medical FSA		<u>Dependent Care FSA</u> <input type="checkbox"/> I elect to participate in the Dependent Care FSA. The amount I elect for the PLAN YEAR is (min. \$250 / max. \$5,000): <div style="text-align: center;">\$ _____ / Plan Year</div> <p>Your annual election will be deducted from your pay in equal installments throughout the plan year</p> <input type="checkbox"/> I DECLINE to participate in the Dependent Care FSA		
3	Direct Deposit Authorization – Complete the banking information if you wish to establish direct deposit with BASIC pacific (or change your current direct deposit banking information on file with BASIC pacific).				
	<p>By completing the banking information below, I hereby authorize BASIC pacific to deposit all reimbursements directly into my personal bank account at the financial institution named below. I understand that I may cancel this authorization at any time by notifying BASIC pacific in writing. I further understand that I am responsible to notify BASIC pacific if, for any reason, my bank account information changes. If I do not sign up for Direct Deposit, I understand all reimbursements will be paid to me by check.</p> <p style="text-align: right;">_____ Checking <input type="checkbox"/> Savings <input type="checkbox"/></p> <p style="text-align: center;">Name of DEPOSITORY (Name of Financial Institution)</p> <p>Bank Routing Number _____ Account Number _____</p>				
4	By signing below, you are agreeing to the terms and conditions printed on the back of this form.				
	<p>I, the undersigned employee, hereby certify that I have read and agree to all the "Terms & Conditions for Participation in the Flexible Benefit Plan" printed on the back of this Election Form. I hereby authorize my employer to deduct the amounts listed above from my compensation.</p> <p>EMPLOYEE SIGNATURE: _____ DATE: ____/____/____</p>				
5	Completed by Employer				
	AUTHORIZED EMPLOYER SIGNATURE	EMPLOYEE DIVISION Name: _____ Unit #: _____	BENEFITS EFFECTIVE DATE (May not precede the date employee signed form)	DATE OF HIRE	DATE OF 1 ST DEDUCTION

Terms & Conditions for Participation in the Flexible Benefit Plan

I fully understand and agree that:

- I may never be reimbursed for expenses “incurred” (the date services are actually performed) prior to the later of, the date I am eligible to participate or the date I complete the enrollment form.
- Once made, my elections are “irrevocable” during the plan year unless I experience a “qualifying and related change in status”. I understand that I must refer to my SPD for details.
- If I am an active employee as of the last day of the plan year, I will forfeit any remaining balance left in my reimbursement account(s) unless BASIC pacific “receives” my claim for qualified expenses by the last day of my “run-out period”.
- If I terminate employment, or otherwise lose my eligibility to participate in the reimbursement accounts during the plan year, I may be required to submit claims for reimbursement shortly after losing my eligibility (refer to your SPD for the filing deadline if you terminate participation during the plan year). If I do not submit my claim for reimbursement by the deadline, I understand and agree that I will forfeit any remaining balance left in my reimbursement account(s).
- I may only receive reimbursements for qualified expenses incurred (date services are performed) during the plan year and while I am an active employee (unless coverage is extended under COBRA).
- I may be reimbursed for expenses incurred by myself, my spouse, my dependent children, and any other individual who qualifies as my federal tax dependent.
- I may never seek reimbursement before an expense is “incurred” (performed).
- By participating in my flexible benefit (cafeteria) plan, I may reduce my Social Security tax contribution, and therefore, could potentially reduce my future social security benefits.
- My employer may modify or revoke my elections at any time if required to maintain the Plan in compliance with all applicable provisions of the Internal Revenue Code (IRC).
- This agreement is subject to the terms and conditions of the Plan and revokes any prior agreement I may have completed.
- I must make a new election each year for my FSA accounts. My FSA elections will not automatically roll-over.
- To save taxes on my health insurance premiums, I must proactively check the box electing to participate in POP benefits each year. Prior to each subsequent Plan Year, if I do not check the box electing POP benefits during my open-enrollment period, I understand that my payroll deductions for group health insurance and/or my cost for specified voluntary health benefit plans will be taxed and I will not be permitted to change my election until the following Plan Year.
- I am responsible to determine if the tax benefits provided by the Dependent Care FSA are superior to the federal tax credit.
- I am responsible to reimburse my employer for any benefits received, taxes, penalties or interest that may be imposed if I knowingly violate the terms of the Plan.
- I have received a Summary Plan Description (SPD) for the Flexible Benefit Plan.