Employee Reimbursement Accounts Enrollment Form

Form Instructions: Please complete all entries on this form. Please print, sign and date this form, and submit to your Employer Benefits Specialist or Payroll Benefits Staff.

STEP 1: Enrollee Personal Information

First Name:	Last Name:	Change Effective Date:
Employer Name:	Employee ID:	
Permanent Address:	City: / State: / Zip Code:	
Day Time Phone Number:	Email Address:	
Social Security Number: __ __ __ / __ __ / __ __ __ __	Date of Birth: (Month/Day/Year) __ __ / __ __ / __ __ __ __	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Enrollment Status: ☐ New enrollment ☐ Re-enrollment	

STEP 2: Health Care FSA Elections (Select Limited Purpose FSA coverage, which is limited to dental, vision, and post-deductible medical expenses, if you also elect the HDHP/Health Savings Account (HSA) plan.)

☐ Select Health Care FSA ☐ Decline Health Care FSA ☐ Select Limited Purpose Health Care FSA ☐ Decline Limited Purpose Health Care FSA

I. Annual Employee Contribution (Not to Exceed Contribution Maximums*)	II. Number of regular pay periods:	III. Contribution per pay period (I divided by II)

*For 2020, Health FSA contributions are limited by the IRS to $2,700 each year. The limit is per person; a married couple may each contribute up to the specified limit.

STEP 3: Dependent Day Care Account Elections

☐ Select Dependent Day Care Account ☐ Decline Dependent Day Care Account

I. Annual Employee Contribution (Not to Exceed Contribution Maximums**)	II. Number of regular pay periods:	III. Contribution per pay period (I divided by II)

**Couples who are married and file a joint return, as well as single parents, can contribute up to $5,000 in a Dependent Care FSA. Couples who are married and file separately can put a maximum of $2,500 each into a Dependent Care FSA.

STEP 4: Commuter Elections

Transit Account ☐ Select Transit Account ☐ Decline Transit Account

I. Annual Employee Contribution***	II. Contribution per month (I divided by 12)

Parking Account ☐ Select Parking Account ☐ Decline Parking Account

I. Annual Employee Contribution***	II. Contribution per month (I divided by 12)

***Beginning January 1, 2019, Commuter contributions are limited by the IRS to $265 per month for transit expenses, and $265 per month for parking expenses. Contributions over $265 a month for transit or $265 a month for parking are considered post-tax contributions.

UW System and UW Hospitals & Clinics employees are not eligible to elect the above Commuter Fringe Benefits.

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STEP 5: Authorization and Certification

Health Care FSA and Dependent Day Care Account

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Funds left in my Dependent Day Care Account at the close of the plan year will be forfeited. Funds left in my Health Flexible Spending Account may be forfeited, per plan rules. See plan documents for more details.
- I will receive a ConnectYourCare Payment Card to access Health Care FSA funds in my account. I certify that:
  - The card will only be used for eligible medical and/ or dependent care expenses.
  - Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

Commuter Account

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified.
- My monthly election is recurring for entirety of the plan year unless the I make an election change.
- I may change my election any month of the plan year, as long as my request is received before the last pay period of the month prior to the new benefit month.

  I must report any administrative errors to my payroll administrator or human resources department within 10 days of the first payroll deduction of the new benefit month.

Account Holder Signature:	Date:

Please also sign and date the signature section on page 4 of this document.

ENROLLMENT TERMS AND CONDITIONS

I elect to participate in Employee Reimbursement Accounts and agree to be bound by the terms of the Plan.

I understand that:

- The Employee Reimbursement Accounts Program (ERA) is an optional benefit established for eligible state employees sponsored by the State of Wisconsin and administered by the Department of Employee Trust Funds (Plan Administrator). The ERA is also referred to as Flexible Spending Accounts or FSAs. The ERA has five pre-tax benefit program options: Health Care FSA, Limited Purpose FSA (LPFSA), Dependent Day Care Account, Transit Account, and Parking Account. The ERA is authorized under Internal Revenue Service (IRS) Code Sections §125, §105, §129, and §132 and Wisconsin Statutes §40.85-§40.875.
- The Plan Administrator reserves the right to amend at any time, any or all of the provisions of the Plan. The Plan Administrator reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be approved by the Group Insurance Board (Board) in accordance with its normal procedures for transacting business. Upon Board approval, affiliated employers may withdraw from participation in the Plan.
- A new enrollment must be completed each plan year. If I do not complete enrollment during open enrollment, I forfeit the opportunity to participate in the Health Care FSA, LPFSA, or Dependent Day Care Account benefit options.
- Contribution(s) are deducted on a pre-tax basis. If I do not wish to have my ERA contributions deducted pre-tax and prefer to be taxed on these dollars, I am to contact my human resource or benefit office.
- Pre-tax contribution deductions reduce my compensation for Social Security benefit purposes.
- According to Wisconsin Statutes §40.87, participation in an ERA will not reduce my wages for calculating state retirement benefits. Also, my contributions in an ERA will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- Contributions made into one account cannot be transferred and used for expenses in any other account.
- Participating in an ERA is completely voluntary, and payments from my ERA are independently reviewed for compliance with IRS regulations.
- The IRS requires me to reimburse the Plan for any improper, erroneous, or excess reimbursement amount that I do not resolve within the timeframe provided by the Plan. In accordance with Wisconsin Statute §40.08(4), by enrolling in an ERA, I specifically authorize the Plan Administrator, Department of Employee Trust Funds and/or my employer to withhold from my wages on a post-tax basis such amounts as are necessary to replenish my ERA for any improper, erroneous or excess reimbursement.
- If my employment terminates, only expenses incurred through my period of coverage as defined by the Plan can be considered for reimbursement.
- Health Care FSA, LPFSA, and Dependent Day Care Account elections can only be changed or revoked during the plan year if I experience a qualified life change event or no longer eligible to participate, as defined by the Plan. The new election must be consistent with my change in status, must be applied for within 30 days of the qualified life change event, and is subject to final approval by the Plan Administrator. I cannot lower my election to an amount that is less than what I have already been reimbursed from my account. Whether I increase or decrease my election, my new election will be spread out evenly over my remaining pay periods.
- Parking Account and Transit Account elections can be changed or revoked prior to the first day of the next monthly coverage period. Elections can only be changed for future months. Upon termination or cessation of eligibility, my elections will be immediately revoked.
- If I am enrolled in a Health Care FSA or an LPFSA, my eligible expenses must qualify as a health care deduction under IRS Publication 502 and 969.
- If I am enrolled in a Dependent Day Care Account, my eligible expenses must qualify as a dependent care deduction under IRS Publication 503. The expenses are for a qualified dependent (child under age 13, spouse, or adult dependent unable to care for themselves), for care by a qualified dependent care provider such as a day care center or by an individual including a non-dependent family member over age 19, inside or outside the home.
- The maximum exclusion under a Dependent Day Care Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.

ENROLLMENT TERMS AND CONDITIONS

- If I am enrolled in a Parking Account or Transit Account, my eligible expenses must qualify as a commuter benefit deduction under IRS Publication 5137.
- At the close of the plan year, any amounts remaining in a Health Care FSA or LPFSA in excess of $500, and any amounts remaining in a Dependent Day Care Account, will be forfeited in accordance with current Plan provisions and tax laws.
- Under IRS and Treasury regulations, payments from the ERA require third-party substantiation unless the transaction is auto-substantiated or substantiated by other appropriate means approved by the Plan. I am obliged to satisfy any documentation requirements and to retain those documents for tax purposes or in the event of an IRS audit. When I am unable to substantiate my claims with a Payment Card transaction, I am to substantiate those claims manually with supporting documentation, if applicable When I make a mid-year ERA contribution election or enrollment change, I am re-certifying to the terms and conditions.
- In circumstances where my Payment Card is lost/stolen or become aware of fraudulent charges, I am to notify ConnectYourCare (CYC) immediately. CYC will deactivate the Payment Card and reissue a new Payment Card.
- If I am found to have used my ERA or Payment Card fraudulently, my participation in the ERA may be terminated and I may lose the ability to participate in the ERA in the future.

I certify that:

- The information that I provided is complete and accurate to the best of my knowledge.
- I agree to have my compensation reduced by the contribution amount(s) I elected on a pre-tax basis. If I do not wish to have my ERA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- All dependents I list in my ERA will meet the eligibility requirements of the program.
- I will not claim a federal income tax deduction or credit for any expenses that were reimbursed through my ERA.
- My use of the Payment Card will comply with the terms and conditions of the Cardholder Agreement received with the Payment Card.
- All expenses charged on the Payment Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed and not reimbursable through any other means, including my or my dependent's insurance plans.
- I will keep all receipts and other documentation related to expenses charged on the Payment Card for account management and tax purposes. Upon request, within eighty-five (85) days, I will fax, mail, or upload the required documentation of expenses to the Third-Party Administrator.
- I understand additional Payment Cards issued to my spouse or dependent(s) will provide the named individual with access to my ERA. I accept responsibility for all Payment Card transactions incurred by the named individual and will submit documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Payment Card in violation of this enrollment agreement or the Cardholder Agreement may result in the invalidation and forfeiture of the Payment Card. If the Third-Party Administrator determines that an expense charged on the Payment Card was not a qualified expense under the Plan or according to IRS rules, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to reimburse the Plan in a timely manner, I understand the amounts may be withheld post-tax from my wages or from an otherwise valid expense in order to reimburse the unqualified expense.

Signature _____ **Date** _____

Return this form to your Employer Benefits Specialist or Payroll Benefits Staff.