Archdiocese of St. Louis Health Insurance
Employee Flexible Spending Plan Election Form

COMPLETED BY EMPLOYER: Please check one of the following:

❒ Open Enrollment Election **(July 1, 2020 through June 30, 2021)**
❒ New Hire Employee **(Plan Year July 1, 2020 through June 30, 2021)**
❒ Change of Contribution Payroll Deduction or Termination of the plan

Effective Date **Qualifying Event for Change**

Date of first paycheck affected

Parish / School / Agency Employer Name

Parish / School / Agency Address

1. EMPLOYEE INFORMATION

Last Name **First Name** **MI**

Home Mailing Address

City **ST** **Zip Code**

Home Telephone Number

Date of Birth **Gender** ❒ Male ❒ Female

Social Security Number xxx-xx-

Marital Status ❒ Married ❒ Unmarried

Employed

2. I elect to allocate the following on a monthly basis: MEDICAL REIMBURSEMENT PLAN

Medical Reimbursement Plan (Do not include employee health insurance premium contributions) ☒

Maximum Allowable Account Amount $2,700 per Plan Year

Payroll Deduction Amount | Total Annual Before-Tax Dollars | ÷ # of Payroll Periods remaining in Fiscal Plan Year | = Contribution per Paycheck

3. I elect to allocate the following on a monthly basis: DEPENDENT CARE REIMBURSEMENT PLAN

Dependent Care Reimbursement Plan

Maximum Allowable Account Amount for Single, Head of Household or Married, Filing Joint Return is $5,000 per Plan Year

Maximum Allowable Account Amount for Married, Filing Separate Return is $2,500 per Plan Year.

Payroll Deduction Amount | Total Annual Before-Tax Dollars | ÷ # of Payroll Periods remaining in Fiscal Plan Year | = Contribution per Paycheck

4. DESIGNATE YOUR BENEFICIARY

I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible spending account should be made payable to the undersigned.

Primary Beneficiary Name **Relationship**

Contingent Beneficiary Name **Relationship**

5. READ AND SIGN

My signature on this form certifies that I have received and read the printed material explaining my employer's flexible spending program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (i.e., marriage, divorce, birth or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.

Signature of Applicant _____ Date _____

Please submit your completed and signed FSA Election Form via fax to 314.792.754
or by mail to Archdiocese Office of Human Resources, 20 Archbishop Dr., St. Louis, MO 63119.

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