



# DIVISION OF STATE GROUP INSURANCE

## FLEXIBLE SPENDING ACCOUNTS - ENROLLMENT FORM

### PLAN YEAR \_\_\_\_\_



Select Your Type of Enrollment:  **New Hire**       **Qualifying Status Change**       **Open Enrollment**  
\* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 3.  
**PLEASE PRINT**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_      SUNCOM: \_\_\_\_\_      Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Sex: \_\_\_\_\_      Payroll Mode:  Monthly       Biweekly

### PART 1: ELECTION AMOUNTS

#### Medical Reimbursement

I choose to participate in the Medical Reimbursement Account and elect: \$ \_\_\_\_\_ \* annual amount for the remainder of the Plan Year

#### Dependent Day Care Reimbursement

I choose to participate in the Dependent Care Reimbursement Account and elect: \$ \_\_\_\_\_ \*\* annual amount for the remainder of the Plan Year

The Plan Year is January 1 through December 31, and the amount(s) you elect is for this Plan Year OR THE REMAINING PORTION OF THE YEAR. The effective date of your enrollment is the date this properly completed form is received by the Personnel Office or the Division of State Group Insurance. Only claims for expenses incurred on or after the effective date could be eligible for reimbursement. Deductions are based on the number of payroll cycles remaining in the Plan Year.

### PART 2: CHANGE IN FAMILY OR EMPLOYMENT STATUS

I have, or will experience a change in family or employment status on (date) \_\_\_\_\_ DOCUMENTATION ENCLOSED  
 My change is (Describe the event) \_\_\_\_\_  
 Therefore, I wish to:

#### Medical Reimbursement

Increase to \$ \_\_\_\_\_ annually.  
 Decrease to \$ \_\_\_\_\_ annually.  
 ENROLL with \$ \_\_\_\_\_ for the remainder of the Plan year\*  
Terminations may be executed on Medical Reimbursement Account - Termination of Employment FB-4 Form.

#### Dependent Care Reimbursement

Increase to \$ \_\_\_\_\_ annually.  
 Decrease to \$ \_\_\_\_\_ annually.  
 ENROLL with \$ \_\_\_\_\_ for the remainder of the Plan year\*\*  
 Terminate Participation

The Division of State Group Insurance will determine if your request is consistent with federal provisions. If you are changing from a prior election, the new amount you elect should be the total dollar amount of ALL contributions you want deducted for the entire Plan Year.

\* Limits for the Medical Reimbursement Account are: Maximum \$2,400; Minimum \$60.

\*\*Limits for the Dependent Care Account are: Maximum \$5,000 if single or married filing jointly, OR \$2,500 if married filing separately; Minimum \$60

Employees who have FSAs and do not want to change their annual elections do not have to do anything during Open Enrollment. Current annual deductions will be continued in the next year.

I authorize the amount(s) elected to be deducted from my salary or wages on a pretax basis. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year in accordance with the Internal Revenue Code Section 125 if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for the expenses are not filed with the Division of State Group Insurance by the claims filing deadline date following the Plan Year (April 15). I further understand that the above elections can NOT be revoked or changed during the Plan Year unless I experience a qualifying change in family or employment status as defined by the IRC and Rule 60P, F.A.C..

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PART 3: AGENCY CERTIFICATION REQUIRED

Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      SAMAS Org Code: \_\_\_\_\_

Coverage Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Employment Status: \_\_\_\_\_      Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Agency Signature: \_\_\_\_\_      Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      SUNCOM: \_\_\_\_\_

\* QSC Code: \_\_\_\_\_      \*QSC Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Check if the employee is an 8, 9 or 10 month faculty member.

# INSTRUCTIONS

Prior to the completion of this form, please read the current Annual Open Enrollment Benefits booklet. The publication will help you estimate eligible expenses and help determine if you will benefit from plan participation. Copies are available from your personnel office or the Division of State Group Insurance (DSGI) - (850) 921-4525 or Suncom 291-4525.

Return this completed form to your personnel office. It must be received within 60 days of your employment or within 31 days of a change in family / employment status. **The effective date of plan participation or change in participation will be based on the date the properly completed form and documentation are received by your personnel office or DSGI.**

## Employee Information

Complete all the personal information that is requested, including your payroll mode.

## Part 1: Election Amount(s)

Check the appropriate boxes and designate the amount(s) you wish to contribute to your Medical and/or Dependent Care Reimbursement Account(s) for the current Plan Year. The Plan Year ends December 31. The annual minimum contribution is \$60 for both the accounts and the maximum contribution is \$2,400 for the Medical Reimbursement Account. The maximum is \$5,000 for the Dependent Care Account if you are single, or married and filing jointly on your income tax, or \$2,500 if you are married filing separately on your income tax.

Contributions from your paycheck will be based on the remaining number of pay periods in the Plan Year when your Enrollment/Qualifying Status Change Form is received by DSGI.

## Part 2: Change in Family or Employment Status

A participant may be allowed to change the annual election amount(s) when a change in family or employment status is experienced, subject to provisions of the Plan. Changes in family or employment status include marriage or divorce of a participant, death of a spouse or dependent, birth, adoption or obtaining legal guardianship of a child, change from part-time to full-time employment or vice versa for a participant or spouse, spouse attaining or terminating employment, unpaid leave over 31 days for participant or spouse and change in dependent eligibility.

Indicate when the change occurred or will occur and the type of change. Attach documentation of the event, i.e. (certificates, licenses, decrees). DSGI will not process your request until the proper documentation is received. Depending on the nature of your change in status, you may be able to enroll, increase, and/or decrease participation. The requested change must be consistent with the event for the enrollment or change to be approved.

## Part 3: Agency Certification

To be processed, this form must be signed and dated by the employee/participant and agency. Your personnel office will complete this section and forward to:

**Division of State Group Insurance  
P.O. Box 6357  
Tallahassee, Florida 32314-6357**



**For questions on completing the form, status of enrollment, how the plan works or claims inquiries call (850) 921-4604, Suncom 291-4604**