COUNTY OF SANTA CRUZ

HC-FSA: HEALTH CARE FLEXIBLE SPENDING ACCOUNT PROGRAM 2010 ENROLLMENT FORM

~ Annual Enrollment Required ~

I hereby elect to participate in the County of Santa Cruz (County) Health Care Flexible Spending Account Program (HC-FSA). I authorize the Plan Year amount of $_________ ($2,400 annual maximum) to be withheld in equal installments of $_________ from each of my bi-weekly paychecks, beginning in pay period ________, during the Plan Year for the purpose of funding my HC-FSA. I understand that this salary deduction will be effective beginning Pay Period One of Calendar Year 2010. If I am hired after Pay Period One of Calendar Year 2010, this salary deduction will be effective my first full pay period of employment with the County and will remain in effect until the last pay period of Calendar Year 2010.

☐ **By checking this box, I elect the optional Payment Debit Card. An annual fee of $14.40 will be deducted from my paycheck.**

☐ **By checking this box, I authorize WageWorks (formerly Creative Benefits, Inc.) to deposit expense reimbursements for qualified health care expenses directly to my bank account. (Please attach a voided check to this enrollment form; deposit slips are not acceptable.)**

I understand that:

- Unless there is a change in my family status specifically provided for in the HC-FSA Plan Document (available on the County Intranet), I cannot change or revoke this benefit election prior to the beginning of the next plan year.
- The Plan Year is January 1 through December 31; however, in accordance with IRS Section 125, the County allows the Plan Year to be extended 2 ½ months. Therefore, expenses incurred from 1/1/11 through 3/15/11 can also be claimed against the 2010 HC-FSA if a balance exists in the account on 12/31/10. I understand that I must submit claims and receipts for reimbursement of eligible expenses NO LATER THAN 3/31/11. **Funds remaining after 3/31/11 will not be refunded.**
- I cannot claim Federal income tax deductions or credits for HC-FSA expenses for which I have submitted claims and receipts for reimbursement.
- Prior to the beginning of each plan year, I must re-elect participation during Open Enrollment.

PLEASE PRINT:

Employee Name: ____

Street Address: ____

City: ______________________________ Zip: ______________

Employee #: ______________________________ Work Phone #: ______________

SIGNATURE: ______________________________ Date: ______________

RETURN THIS COMPLETED FORM TO THE BENEFITS OFFICE
NO LATER THAN 5:00 PM ON THURSDAY, DECEMBER 10, 2009

QUESTIONS? contact the Benefits Hotline by e-mail at: benefits.questions@co.santa-cruz.ca.us
or call (831) 454-2241 (press 9 to leave a message).