ARE YOU OR A SPOUSE ENROLLED IN AN HSA? IF YES, STOP AND SPEAK WITH YOUR HUMAN RESOURCES DEPARTMENT BEFORE ENROLLING IN THIS PLAN

This is a two-page form. Be sure it has a back side.

Vestal Central School District – VTA | **PLAN YEAR** Oct '20 Sept '21 | ALL INFORMATION MUST BE PROVIDED. PLEASE PRINT IN INK.

LAST NAME | FIRST | INITIAL | SOCIAL SECURITY NUMBER ___-___-____

STREET ADDRESS (Please include any PO BOX#, Apt#, etc.)

CITY | STATE | ZIP CODE

SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | HIRE DATE | CURRENT MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

WORK PHONE ( ) - | HOME PHONE ( ) - | JOB TITLE | LOCATION

LIST BELOW DEPENDENTS THAT ARE DEFINED BY IRC SECTON 105(B) AS ELIGIBLE FOR TAX FREE HEALTH BENEFITS AND YOUR SPOUSE (According to Federal Law) OR DOMESTIC PARTNER WHO ARE DEPENDENTS FOR INCOME TAX RETURN PURPOSES

LAST NAME (IF DIFFERENT)	FIRST NAME	DATE OF BIRTH MO	DAY	YR	RELATIONSHIP HUS	WIF	SON	DAU	Please indicate if any person is NOT covered by a group health plan.
					☐				
							☐	☐	
							☐	☐	
							☐	☐	
							☐	☐	

Spousal Information

If you or any of your dependents are covered under a health benefit plan not listed below, such as for children of divorced or separated parents, or children covered under NYS Child Health Plus, or yourself covered under a previous employer plan, please supply that information and attach to this form.

IS YOUR **SPOUSE** EMPLOYED? ☐ YES ☐ NO IF YES, NAME OF EMPLOYER : _____

IS YOUR **SPOUSE** COVERED UNDER **HIS/HER** EMPLOYER'S HEALTH PLAN? ☐ YES ☐ NO

NAME OF CARRIER: _____

☐ MEDICAL COVERAGE ☐ DENTAL COVERAGE ☐ VISION COVERAGE

DOES THIS INSURANCE COVER : ☐ SPOUSE ONLY ☐ SPOUSE AND FAMILY

Self

ARE YOU COVERED UNDER **YOUR** EMPLOYERS MEDICAL PLAN? ☐ YES ☐ NO ☐ SINGLE ☐ FAMILY

ARE YOU COVERED UNDER **YOUR** EMPLOYERS DENTAL PLAN? ☐ YES ☐ NO ☐ SINGLE ☐ FAMILY

I ELECT to enroll in the Flexible Benefits Program and hereby authorize the following salary redirection. I understand that:

PLEASE READ THE REVERSE SIDE BEFORE SIGNING THIS FORM.

1) I may not change my election during the year except for a change of status..
2) I will forfeit any balance less than $10 and greater than $500 that remains 90 days after the Plan Year.
3)If I terminate from this Plan, I have 90 days to submit claims incurred prior to my termination date for my Medical Flexible Spending Account and/or dependent care account. Inquire if you are eligible to elect COBRA for your Medical FSA.
4) I understand that this reduction of my cash compensation could affect my Social Security Benefits.
5) I understand I am responsible for keeping all my receipts/itemized bill/EOB's etc. for claim substantiation and potential tax purposes. My card could be suspended if I do not comply with substantiation requirements.
6) I am responsible for the cost of reissuing or replacing my debit card.
7) VTA $2000

	Plan Year MAXIMUM	Employer Plan Year Election	Per Pay Period
UNREIMBURSED MEDICAL	REFER to #7 ABOVE	$	$
DEPENDENT CARE EXPENSES - (Daycare)	$5000	$	$
TOTAL		$	$

By providing my email address below, I authorize SIEBA, LTD to contact me regarding claim questions and other information related to my flex plan. This email address will not be used for any other purpose.

email address_____

X_____ DATE _____

SIGNATURE

FOR OFFICE	EFFECTIVE DATE	EMPLOYEE'S PAY PERIOD FORMAT

VESTAL VTA.

QUALIFYING UNREIMBURSED MEDICAL EXPENSES

(only eligible expenses NOT reimbursed by other benefit source can be claimed)

Expenses are eligible in accordance with Section 213, Section 105(b) and Section 125 of the IRC. Refer to IRS publication 502 for guidance, as all eligible expenses that are deductible on your income taxes are NOT always reimbursable through a Flexible Benefit Program. Publication 502 can be found at www.sieba.com.

Abortion (legal)
Alcoholism & drug abuse center
Ambulance hire
Artificial limbs & teeth
Automobile modifications
(hand controls, special equipment, mechanical lifts)
Birth control pills
Braille books & magazines
Childbirth classes - mother only
*****Co-insurance amounts, co-pay amounts
Crutches
Deductibles
Elastic hose, medically prescribed
***RX Eye glasses/contact lenses & solutions**
Fees:
Acupuncture
Anesthetist
Chiropractor
Clinic
Dentist
Diagnosis
Examination,physical
Eye examination

Fees con't:
Gynecologist
Hospital
Laboratory
Lip reading lessons for the deaf
Medical information plan
Midwife
Nurse
Obstetrician
Ophthalmologist
Optician
Optometrist
Oral surgery
****Orthodontist**
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist
Practical nurse
Psychiatrist
Psychologist
Specialist
Surgeon
Therapy as a medical treatment

Guide dog or other animal
Hearing devices
***Hospital bills
Iron lung, operating cost
****Medicine including insulin**
Nursing care
Obstetrical expense
Operations & related treatments
Oxygen equipment
Refractive eye surgery
Rental of healing or medical equipment
Seeing-eye dog
Special education
Television set modifications to receive closed captions
Support or corrective devices
Telephone for deaf
Therapy treatments
Transportation expense
Relative to illness
$.17 for 2020
X-rays
Wheelchair

*** Contact lens or eye glass insurance or service agreements are NOT reimbursable through an unreimbursed medical account.**
**** Medicine/drug as excludable from gross income as allowed by §105(b). Illegally imported drugs are not reimburseable. Refer to "Things to Know" flyer for important changes regarding OTC products effective 1/1/20 as a result of the CARES Act.**
***** TV & Telephone charges from a hospital stay are not eligible for reimbursement through an unreimbursed medical account.**
****** Please contact SIEBA if you are using your account for Orthodontic services for a detailed explanation of eligible expenses.**
******* Medicare and other Insurance Premiums are NOT reimbursable through an un-reimbursed medical account.**

You cannot include in medical expense an item ordinarily used for personal, living, or family purposes unless it is used primarily to cure or alleviate a physical or mental defect or illness. Where an item purchased in a special form primarily to alleviate a physical defect is one that in normal form is ordinarily used for personal, living, or family purposes, the excess of the cost of the special form over the cost of the normal form is a medical expense.

Some of the above expenses may require additional documentation from your physician such as letters of medical necessity. If in doubt, please feel free to contact SIEBA, LTD.

Expenses categorized as COSMETIC PROCEDURES are NOT reimbursable. For example; The use of RETIN A for wrinkles, teeth whitening and bleaching, orthodontia for solely cosmetic purposes are NOT reimbursable. Spider Vein and Varicose Vein Treatment COULD also be considered Cosmetic in nature. Check with your health benefit carrier prior to making your election. If your health carrier considers the procedure as cosmetic in nature, your flex plan would as well.

QUALIFYING DEPENDENT CARE EXPENSES

In brief, expenses must be paid to a dependent care center or care provider. (Overnight camp is ineligible) The provider must declare their income and provide the participant with a tax identification number or social security number (W-10). Form 2441 or Schedule 2 must be completed with your income tax return. Eligible expenses are those expenses paid for the care of a dependent under age 13 or expenses paid for care of other dependents who are physically or mentally incapable of caring for themselves. Expenses must be incurred to enable the employee and if married, his/her spouse, to be gainfully employed. The maximum amount allowable under IRS Guidelines to set aside on a pre-tax basis for eligible dependent care expenses is $5000 if you are married, filing a joint tax return, or a single head of household, or $2500 if you are married filing separate tax returns. **If your spouse is also eligible to participate in a dependent care account, the maximum amount allowable to set aside per household is $5000.** Daycare expenses incurred while a parent is out on medical leave such as maternity leave or other leave of absence (paid or unpaid) are not eligible for reimbursement.

Please refer to IRS Publication 503 for specifics relating to eligible dependent care expenses which can be found at www.sieba.com .

Once an election has been made, it CANNOT be changed. We strongly recommend that if you have any questions regarding the eligibility of an expense, you contact the claim administrator, SIEBA, LTD. at (607) 786-3003 or (800) 252-4624 BEFORE making any election.

Eligibility of expenses is subject to change based on current tax laws. ***April 20, 2020***

SIEBA LTD
SPECIALISTS IN EMPLOYEE BENEFIT ADMINISTRATION