

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

FLEXIBLE and HRA BENEFITS PROGRAM ENROLLMENT FORM

Vestal Central School District except VTA		Plan Year Oct '22 - Sept '23	ALL INFORMATION MUST BE PROVIDED (PLEASE PRINT IN INK)		
LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NUMBER		
STREET ADDRESS (PLEASE ADD ANY PO BOX#, APT#, etc)					
CITY	ZIP CODE	STATE	WORK PHONE	HOME PHONE	
SEX	DATE OF BIRTH	HIRE DATE	JOB TITLE		
CURRENT MARITAL STATUS (Check one) MARRIED SINGLE DIVORCED SEPARATED WIDOWED DOMESTIC					

LIST BELOW DEPENDENTS THAT ARE DEFINED BY IRS SECTION 105(B) AS ELIGIBLE FOR TAX FREE HEALTH CARE BENEFITS, YOUR SPOUSE UNDER FEDERAL LAW, OR DOMESTIC PARTNER WHO IS A DEPENDENT FOR INCOME TAX RETURN PURPOSES. IF YOU ARE LISTING SOMEONE OTHER THAN YOUR SPOUSE, CHILD(REN), OR STEP CHILD(REN), SUCH AS A GRANDCHILD, PLEASE PROVIDE DOCUMENTATION VERIFYING TAX DEPENDENCY.

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP TO THE SUBSCRIBER	Please indicate if any person is NOT covered by a group health plan.

If you or any of your dependents are covered under a health benefit plan not listed below, such as for children of divorced 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.

EMPLOYEE	DO <u>YOU</u> CARRY INSURANCE THROUGH YOUR EMPLOYER ?			CHECK ONE: YES OR NO
	If yes:	Medical Coverage	Single or Family	Name of Carrier:
		Dental Coverage	Single or Family	Name of Carrier:
		Vision Coverage	Single or Family	Name of Carrier:
	IF UNDER THE AGE OF 27, ARE <u>YOU</u> COVERED UNDER A PARENT'S INSURANCE?			CHECK ONE: YES OR NO
SPOUSE	IS YOUR SPOUSE EMPLOYED? YES OR NO IF YES, NAME OF EMPLOYER?			
	Does your spouse carry insurance through his/her employer or some other carrier?			CHECK ONE: YES OR NO
	If yes:	Medical Coverage	Single or Family	Name of Carrier:
		Dental Coverage	Single or Family	Name of Carrier:
	Vision Coverage	Single or Family	Name of Carrier:	

ENROLLMENT ELECTION

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

- 1) I may not change my election during the year except for a change of status.
- 2) I will forfeit any balance in my Medical FSA that remains 90 days after the end of 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 that I am responsible for keeping all my receipts/itemized bills/EOB's, etc. for claim substantiation and potential tax purposes. My card could be suspended if I do not comply with substantiation requirements. I understand I am responsible for reissuing additional cards or replacing a lost/stolen/never received debit card.
- 6) VEA \$2000. AVSP \$1000. VAA \$2500. VSA \$2850. SOS \$2850.

Plan Year Maximum refer to #6 above		Employee Plan Year Election	Per Pay Period
UNREIMBURSED MEDICAL	See #6		
DEPENDENT CARE (DAY CARE)	\$ 5,000.00		
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. By signing this form, I agree to the rules and regulations put forth under IRS §125 those listed above and on the reverse side of this form.

Email Address:		FOR OFFICE	EMPLOYEE'S PAY PERIOD FORMAT	EFFECTIVE DATE
Signature: X	Date:			

****HOUSEHOLD YEARLY MAXIMUM IS \$5,000.00 (DEPENDENT CARE)**

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)	Fee's con't	Laboratory	Fee's con't	Guide dog or other animal
Alcoholism & drug abuse center		Lip reading lessons for the deaf		Hearing devices
				***Hospital bills
Ambulance hire		Medical information plan		Iron lung, operating cost
Artificial limbs & teeth		Midwife		**Medicine including insulin
Automobile modifications (hand controls, special equipment, mechanical lifts)		Nurse		
				Menstrual Care Products
Birth control pills		Obstetrician		Nursing care
Braille books & magazines		Ophthalmologist		Obstetrical expense Operations & related treatments
Childbirth classes-mother only		Optician		
****Co-insurance amounts, co-pay amounts		Optometrist		Oxygen equipment
				PPE - face masks, hand sanitizer
Crutches		Oral surgery		
Deductibles		****Orthodontist		Refractive eye surgery
				Rental of healing or medical equipment
Elastic hose, medically prescribed		Osteopath		Seeing-eye dog
*RX Eyeglasses/contact lenses & solutions		Pediatrician		Special education
Fees:	Acupuncture	Physician		Television set modifications to receive close-caption
	Anesthetist	Physiotherapist		Support or corrective devices
	Chiropractor	Podiatrist		Telephone for deaf
	Clinic	Practical Nurse		Therapy treatments
	Dentist	Psychiatrist		Transportation expense relative to illness.
	Diagnosis Examination, physical	Psychologist		\$.18 for 1/1/22-6/30/22 & \$.20
		Specialist		7/1/22-12/31/22
	Gynecologist			X-rays
	Hospital	Surgeon		Wheelchair
		Therapy as a medical treatment		

* **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 reimbursable. Refer to "Things to Know" flyer for important changes regarding OTC products effective 1/1/2020 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 unreimbursed 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 a Schedule 2 must be completed with your income tax return. Eligible 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. Expense must be incurred to enable the 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 expense is subject to change based on current tax laws.