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 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 PARTNER

LIST BELOW DEPENDENTS THAT ARE DEFINED BY IRS SECTION 105(B) AS ELIGIBLE FOR TAX FREE HEALTH 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 **YOU** 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 **YOU** 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 autorize 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 is less than $10 and greater than $570 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 fo 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 addtitional cards or replacing a lost/stolen/never received debit card.

Plan Year Maximum		Employee Plan Year Election	Per Pay Period
UNREIMBURSED MEDICAL	$ 2,000.00		
DEPENDENT CARE (DAY CARE)	$ 5,000.00		
TOTAL	$ 7,000.00		

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	EEFFECTIVE 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, Section105(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 throug 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

- Gynecologist
- Hospital

Fee's con't

Laboratory
Lip reading lessons for the deaf

Medical information plan
Midwife
Nurse

Obstetrician
Ophthamologist
Optician
Optometrist

Oral surgery
****Orthodontist

Osteopath
Pediatrcian

Physician
Physiotherapist
Podiatrist

Practical Nurse
Psychiatrist
Psychologist
Specialist

Surgeon
Therapy as a medical treatment

Fee's con't

Guide dog or other animal
Hearing devices

***Hospital bills
Iron lung, operating cost
**Medicine including insulin

Menstral Care Products
Nursing care
Obstetrical expense
Operations & related treatments

Oxygen equipment
PPE-face masks, hand sanitizer

Refractive eye surgery
Rental of healing or medical equipment

Seeing-eye dog
Special education
Television set modifications to receive close caption

Support or corrective devices
Telephone for deaf
Therapy treatments
Transportation expense relative to illness. $.18 for 1/1/22-6/30/22 & $.20 7/1/22-12/31/22

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 reinburseable. 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 accont for othdontic 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 primarly to cure or alleviate a physical or mental defect or illness. Where an item purchased in a special form primarily to alleviat 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 catergorized as COSMETIC PROCEDURES ar NOT reimbursable. For example; The use of RETIN A for wrinkles, teeth whitening and bleaching, orthodontia for soley 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 in capable of caring for themselves. Expense must be incurred to enable the expenses is $5000 if your 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 reimbursment.

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 eligibilty 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.