

****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 2023 - Sept 2024	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 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 is less than \$10 and greater than \$610 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.

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	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)	Fees cont':	Guide dog or other animal
Alcoholism & drug abuse center	Gynecologist	Hearing devices
Ambulance hire	Hospital	***Hospital bills
Artificial limbs & teeth	Laboratory	Iron lung, operating cost
Automobile modifications	Lip reading lessons	**Medicine including insulin
(hand controls, special	for the deaf	Menstrual Care Products
equipment, mechanical lifts)	Medical information plan	Nursing care
Birth control pills	Midwife	Obstetrical expense
Braille books & magazines	Nurse	Operations & related treatments
Childbirth classes - mother only	Obstetrician	Oxygen equipment
****Co-insurance amounts, co-pay	Ophthalmologist	PPE-face masks, hand sanitizer
amounts	Optician	Refractive eye surgery
Crutches	Optometrist	Rental of healing or
Deductibles	Oral surgery	medical equipment
Elastic hose, medically prescribed	****Orthodontist	Seeing-eye dog
*RX Eye glasses/contact lenses &	Osteopath	Special education
solutions	Pediatrician	Television set modifications to
Fees:	Physician	receive closed captions
Acupuncture	Physiotherapist	Support or corrective devices
Anesthetist	Podiatrist	Telephone for deaf
Chiropractor	Practical nurse	Therapy treatments
Clinic	Psychiatrist	Transportation expense
Dentist	Psychologist	Relative to illness
Diagnosis	Specialist	\$.22 for 2023
Examination, physical	Surgeon	
Eye examination	Therapy as a medical	X-rays
	treatment	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 reimbursable. 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. Eligible amounts will also vary if there is a divorce or a separation. Please call to verify or consult with a tax accountant.

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.

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