2017 FSA Enrollment Form

East Ohio Conference of the United Methodist Church

PLEASE PRINT LEGIBLY:

Name: ______________________________ SS#: ______________________________

Address: ______________________________ Phone: ______________________________

City: ______________________________ State: _________ Zip: ______________________________

Email Address (required): ______________________________ Date of birth (required): ______________________________

(Please provide office email to receive email confirmations for receipt of claims and check disbursements)

Definition of eligible dependent includes spouse and any person who satisfies the definition of dependent within the meaning of Section 152 of the Code. (Will be reported as a financial dependent on your personal tax return or legally required to pay for medical expenses).

My employer and I hereby agree that my cash compensation will be reduced as outlined below and will be taken from my pay in equal installments during the plan year.

Please check applicable lines:

______ **Check here if the East Ohio Treasurer's Office is your church's payroll service**

______ Check here if this is a change in your current year's election due to a status change

______ Check here if you **plan to retire this year and wish to participate using *accelerated funding***

Healthcare Reimbursement Enrollment:	**Per MONTH Election:**	**Annual Election:**
(Note: Do not include premium contributions in this amount)		
Total Amount Desired to Fund Healthcare Flexible Spending Account *(maximum annual election $2,600)* *(For ease in administration use; $2,599.92 monthly $216.66)*	$ ______________	$______________

it is helpful to all involved parties, if your "Per MONTH Election" is in whole dollars and/or even cents , i.e., $25.00, $48.50 NOT $25.13 or $42.47

Dependent Care Reimbursement Enrollment:		
(i.e., after school childcare, preschool, etc.)		
Total Amount Desired to Fund Dependent Care Flexible Spending Account *(cannot exceed $5,000 per plan)*	$ ______________	$______________

The Benefits Office must receive all documents/enrollments by DECEMBER 12, 2016 for January 1, 2017 participation. NO EXCEPTIONS!

Facsimiles accepted (330) 966-7581. Copies to be distributed by the Plan Administrator to:

1. Participant
2. Payroll personnel at the local church
3. Betsy Stewart, Benefits Manager
   EOC Benefits Office
   8800 Cleveland Ave., N.W., P.O. Box 2800

I understand that:

- This election is effective for the January 1, 2017 through December 31, 2017 plan year and will continue until the end of the plan year unless changed because of a change in status.
- Reimbursement will be available only for "qualifying expenses." I agree to notify the company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the company for any liability it may incur for failure to withhold federal, state or local income tax or social security tax from any reimbursement I receive for a non-qualifying expense, up to the amount of additional tax actually owed by me.
- I cannot change or revoke this compensation reduction agreement at any time during the year unless I have a change in status (including marriage, divorce, death of a spouse or adoption of a child, termination of employment of a spouse and such other events as the Plan determines will permit a change or revocation).
- Any unused balance in my account(s) at the end of the plan year or upon my ceasing participation in the plan (and the applicable run-out periods) will be forfeited.
- This agreement will automatically terminate if the Plan is terminated or discontinued.
- The Plan Administrator may reduce or cancel my compensation reduction agreement or otherwise modify this agreement in the event it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.
- By reducing my compensation on a before-tax basis, my Social Security benefits may be reduced.

This agreement is subject to the terms of the **East Ohio Conference of the United Methodist Church** (as may be amended) and revokes any prior election and compensation reduction agreement relating to these options of the Plan.

Employee Signature:______________________________ Date: ______________________________

Church Name: ______________________________ District: ______________________________