LANSING COMMUNITY COLLEGE
Human Resources

Flexible Spending Account Enrollment/Change Form

For Calendar Year 1/1/2019 through 12/31/2019

Enrollment ☐ Re-Enrollment ☐ Change ☐

EMPLOYEE INFORMATION:

Name (Last, First, MI):	**Home Street Address:**
Social Security Number:	**City:** **State:**
Birth Date (MM/DD/YYYY): **Age:**	**ZIP Code:**
Email Address:	**Telephone (home/cell):**

DEPENDENT INFORMATION:

Relationship (to employee)	**Name** (Last, First, MI)	**Birth Date** (MM/DD/YYYY)	**Gender** (F/M)	**Social Security Number**	**Extra Card** (Y/N*)
			Select one		Select one:
			Select one		Select one:
			Select one		Select one:
			Select one		Select one:
			Select one		Select one:

*A charge of $10.00 will be assessed for each dependent card (debited out of your flexible spending account).

ELECTION INFORMATION:

Account Options	**Maximum Annual Election**	**Enter Per Pay Amount**	**Number of Pays** (26 Total for Year)	**Annual Election**
Health Care FSA	$2,550	$	X	= $
Dependent Care FSA*	$5,000	$	X	= $

*Dependents must be under age 13 to qualify for Dependent Care expenses under the FSA.

EMPLOYEE CERTIFICATION AND SIGNATURE:

I hereby apply for the options listed above. I authorize Lansing Community College to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in force throughout the plan year, unless I have a change in family status. I understand, also, that any money remaining in my account(s) at the end of the plan year will be forfeited. For the Health Care FSA, I further understand and agree to the terms on the back of this form.

EMPLOYEE SIGNATURE: DATE:

Flexible Benefit Plan Payroll Reduction Agreement

Health Care Flexible Spending Account (FSA) Authorization

I hereby consent to have my compensation reduced by the amounts indicated on the Enrollment/Change Form for my contributions to my Health Care Flexible Spending Account (FSA), and my signature on this form fully authorizes Lansing Community College to reduce my compensation in the indicated amounts.

I also agree that if I terminate my participation in the Health Care FSA Plan, Lansing Community College may reduce, to the extent allowed by law, any wage, leave time or other compensable time payments owing to me by an amount equal to the difference, if any, between (1) the amounts by which I was reimbursed from my Health Care FSA prior to my termination date and (2) the amounts contributed by me to my Health Care FSA prior to my termination date. My signature on this form fully authorizes Lansing Community College to reduce any compensable time payments to me by the necessary amount.

I further agree that if Lansing Community College paid out of my Health Care FSA, whether by inadvertence or design, more than I was entitled to receive, Lansing Community College may withhold amounts from my wages until the improperly paid amount has been recovered. My signature on this form fully authorizes Lansing Community College to reduce my compensation to recover amounts improperly paid from my Health Care FSA.

I understand that the Enrollment/Change Form and this Payroll Reduction Agreement must be filed with Lansing Community College before the beginning of the Plan Year in order for it to be effective and that my election may not be modified during the Plan Year unless I have a change in family status, as defined by IRS rules.

I understand, also, that I may not take tax benefits on my annual 1040 tax returns for those monies utilized in this plan.