

2010

KNOX COUNTY GOVERNMENT FLEXIBLE SPENDING ACCOUNT FORM

EE# _____

Plan Annual

Effective Date: _____
To be determined by HR Staff

Participation Limits:

Minimum \$ 250.00

Maximum \$ 5,000.00



PLEASE READ & FILL OUT FORM COMPLETELY

New Hire Open Enrollment Qualifying Event

Date of Hire: _____

Last Name

First Name

MI

Participant TASC ID # (if known)

Street Address

City

State

Zip

Elected / Appointed Official

Department

Daytime Phone: _____

Medical

By signing this form, I authorize my employer to deduct the following annual amount for eligible medical expenses:

Annual amount elected \$ _____

How often are you paid?

Every 2 weeks (26) Twice a month (24)

Dependent Care

By signing this form, I authorize my employer to deduct the following annual amount for eligible dependent care expenses:

Annual amount elected \$ _____

How often are you paid?

Every 2 weeks (26) Twice a month (24)

Check here if you request your spouse to have his/her own card privileges for 2010.

Spouse's Name: _____

- This agreement is subject to the terms of my Employer's Medical Reimbursement Plan, and this Election shall take effect as a sealed instrument under applicable laws and revokes any prior election and compensation reduction agreement relating to the Employer's FSA. I am aware that if I enroll in the MFSA or DFSA Section 125 Medical Reimbursement Plan I will receive a Benefits Card in which to purchase eligible expenses.
 - I understand I **MUST** keep receipts for each and every FSA purchase to remain in compliance with IRS guidelines and the rules set forth by my employer. Should I fail to substantiate requested receipts within 30 days my card may be temporarily deactivated.
 - I understand I cannot change or revoke my election mid-year unless I experience a change in status as defined by the IRS.
 - I understand this election is valid for the 2010 plan year only, and that each year I am required to make a new election.
 - Should I misuse this card, I will be required to repay my employer the amount of the ineligible expense. My employer has the right to deduct any unsubstantiated or ineligible item from my paycheck on an after tax basis or collect this amount in the form of a personal check or bank check.
 - Again, I understand the critical nature of **KEEPING ALL RECEIPTS** for purchases under the plan!
 - My Spouse - if applicable - has read and understands all rules and documents that pertain to this plan and card use.
- I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current Plan provisions and tax laws.

Employee Signature: _____ **Date:** _____

Spouse's Signature: _____ **Date:** _____