Health FSA

Health Flexible Spending Account (FSA)
Enrollment and Salary Reduction Authorization
Mid-year Enrollment – Plan year 2011

Participant Information

Employee Name ______________________ Employee ID Number *required* ______________________

Mailing Address Street ______________________ Email Address ______________________

City ______________________ State __________ Zip __________

Office / Dept. Name ______________________ Office Phone Number ______________________

Before-Tax Allocations

Annual Enrollment (full plan year 1/1-12/31)
Mid-year start date is the first pay date with a contribution.

	Pay Period Amount		# of Pay Periods		Total for the year	Not to Exceed
Partial Plan year	$ __________	x	__________	=	$ __________	**$3,900.00**

Minimum**: $5/pay period or $130/yr;** Maximum**: $150 or $3900/yr.**

Authorization and Agreement

I authorize the County of Sonoma to deduct the before-tax amount shown above from my paycheck each pay period. This amount will be directed into my Health FSA account maintained by the County. My account will be used to reimburse me for eligible health care expenses incurred during the period of coverage.

I have read the Flexible Spending Account (FSA) Reimbursement Program brochure and I understand this authorization is for the period of coverage specified above. I understand these payroll deductions **cannot be changed** during the plan year, unless I experience a change in status as defined by the IRS and submit a completed Change in Election form within 31 days of the change event. I further understand that any unused amounts remaining in my Reimbursement Account at the end of the plan's "grace period" will be forfeited, as required by law.

Claims may be filed up to March 31, 2012 for eligible expenses incurred during the 2011 calendar year and the plan's "grace period" (January 1, 2011 through March 15, 2012).

Employee Signature ______________________ Date Signed ______________________

Return completed forms to ACTTC Central Payroll

575 Administration Dr., Rm. 117A, Santa Rosa, CA 95403

Before submitting this form, please make a copy for your records.

FOR COUNTY USE ONLY:

Coverage begin date: ❒ ______________ 2011 County Representative Initials: __________

❒ eP ❒ Vendor number ______________ ❒ Confirmation Statement ❒ Welcome Packet

Original: Auditor Central Payroll **Copy:** Enrollee will receive a copy of the approved Enrollment form in the Welcome Packet