



**STATE EMPLOYEE HEALTH PLAN (SEHP)
FLEXIBLE SPENDING ACCOUNT
ENROLLMENT AND CHANGE FORM**
(PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM)

**FOR
HR
USE
ONLY**

Employee ID #	
State Agency #	
Effective Date	

EMPLOYEE INFORMATION – (EMPLOYEE MUST COMPLETE)

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER

NEW ENROLLMENT

TYPE OF ACTION (CHECK ONE)

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> New Employee Date of Hire: / /	<input type="checkbox"/> Other (Specify) _____ Date of Occurrence: / /
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Health Care Flexible Spending Account (For medical, dental and vision expenses for you and your family)	Semi-Monthly Amount _____	X	Number of Pay Periods _____	=	Annual Amount _____
Dependent Care Flexible Spending Account (For daycare or babysitting expenses)	Semi-Monthly Amount _____	X	Number of Pay Periods _____	=	Annual Amount _____

CHANGE IN ENROLLMENT SEMI-MONTHLY AMOUNT

<input type="checkbox"/> Health Care Account (For medical dental and vision expenses for you and your family)	FROM: _____	TO: _____
<input type="checkbox"/> Dependent Care Account (For daycare or babysitting expenses)	FROM: _____	TO: _____

TYPE OF CHANGE (CHECK ONE)

<input type="checkbox"/> Name change from: _____	<input type="checkbox"/> Leave Without Pay – Estimated Return Date: ____/____/____	<input type="checkbox"/> Leave Under FMLA	<input type="checkbox"/> Return from Leave	<input type="checkbox"/> Change in Employment Status	<input type="checkbox"/> Benefits Eligible Position	<input type="checkbox"/> Benefits Ineligible Position
<input type="checkbox"/> Termination	<input type="checkbox"/> Change in Dependent Care Provider					

REQUESTS FOR THE FOLLOWING CHANGES MUST BE COMPLETED AND RECEIVED WITHIN 31 DAYS OF OCCURRENCE, ALONG WITH SUPPORTING DOCUMENTATION:

<input type="checkbox"/> Marriage of Employee	<input type="checkbox"/> Childbirth/Adoption
<input type="checkbox"/> Final Divorce of Employee	<input type="checkbox"/> Other(specify): _____
<input type="checkbox"/> Spouses 's Gain or Loss of Employment which affects FSA coverage	

DIRECT DEPOSIT REIMBURSEMENT (FLEXIBLE SPENDING ACCOUNTS ONLY – WILL NOT CHANGE AT OPEN ENROLLMENT UNLESS REQUESTED)

Please go to www.kansasfsa.com to complete a Direct Deposit Form with NueSynergy. Direct Deposit is the **only** form of reimbursement for all transactions not processed with your FSA debit card.

AUTHORIZATION (CHECK ONE)

<input type="checkbox"/> I hereby authorize the salary reduction for Flexible Spending Accounts by the amounts listed above. I understand and agree to the terms of enrollment as listed on the reverse side of this form.	<input type="checkbox"/> I wish to discontinue my Flexible Spending Account salary reduction as indicated above.
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EMPLOYEE AUTHORIZATION: By my signature below, I agree to the Terms and Conditions as listed on the reverse of this form. I also understand that I must provide supporting documentation regarding any qualifying event along with this enrollment form in order for my form to be processed.

Signed: _____ Date: _____
EMPLOYEE SIGNATURE – DO NOT PRINT

PERSONNEL OFFICER AUTHORIZATION: By my signature below, I understand that incomplete forms and forms submitted without required supporting documentation will be returned to me and must be returned to SEHP within 31 days of the qualifying event.

Personnel Officer Printed Name: _____
Personnel Officer Signature: _____
Telephone # (include ext.): _____ Date: _____

**AUTHORIZATION: TERMS AND CONDITIONS
FLEXIBLE SPENDING ACCOUNTS**

- Participation in the Flexible Spending Accounts means that your gross pay will be reduced by the amounts contributed to the accounts before federal, state and Social Security taxes are deducted.
- If the first salary reduction on your pay warrant does not match either the account or the amount on your Enrollment Form, it is your responsibility to contact your personnel office no later than 14 calendar days following the date the pay warrant was issued. If you fail to take this action, you waive your right to correct your election for the remainder of the current plan year.
- You cannot change or stop your election until the next open enrollment period unless you experience a qualifying event. The requested change must be consistent with the event.
- If you experience a qualifying event, you must complete an Enrollment and Change Form within 31 calendar days of the event causing the change. You must provide supporting documentation of the event.
- All qualified changes will be processed on a prospective "future forward" basis. Any claim made as a result of a Qualifying Event will only be payable as of the first of the month following the receipt and approval of the change request. Contribution increases can only be used for expenses incurred on the effective date of a change and after.
- You cannot transfer money between your spending accounts.
- Expenses for which you are reimbursed cannot be deducted on your federal and state income tax returns.
- Claims for reimbursement of eligible healthcare expenses during a plan year must be filed before April 30 following the end of that plan year. Any amounts remaining in either spending account after 120 days from the end of the plan year will be forfeited.
- You will be reimbursed for Health Care and Dependent Care Flexible Spending Account (FSA) expenses with dates of service between January 1 and December 31 of the current plan year, and for the Health Care FSA, expenses incurred in the grace period from January 1 through March 15 of the next calendar year. There is no grace period for the Dependent Care FSA. Expenses are incurred on the date of service not the date payment is received. If you enroll in either account after January 1, you will be reimbursed for only those expenses incurred starting with the effective date of your participation in the accounts.
- Any dependent(s) for whom you have elected the Dependent Care FSA must reside with you and/or are legally dependent on you for their support.
- If your spouse is also enrolling in the Dependent Care FSA, your total combined maximum for the two accounts may not exceed \$5,000 per year.
- I have read and agree to the provisions in the State of Kansas Benefits Guidebook.