



**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: / /
---	---	--

Health Care Flexible Spending Account <small>(For medical, dental and vision expenses for you and your family)</small>	Semi-Monthly Amount	Number of Pay Periods	Annual Amount
_____	X	=	_____

Dependent Care Flexible Spending Account <small>(For daycare or babysitting expenses)</small>	Semi-Monthly Amount	Number of Pay Periods	Annual Amount
_____	X	=	_____

CHANGE IN ENROLLMENT SEMI-MONTHLY AMOUNT

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

TYPE OF CHANGE (CHECK ONE)

- Name change from: _____
- Leave Without Pay – Estimated Return Date: ____/____/____
- Leave Under FMLA
- Return from Leave
- Change in Employment Status to Benefits Eligible Position Benefits Ineligible Position
- Termination
- Change in Dependent Care Provider

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

- Marriage of Employee Childbirth/Adoption
- Final Divorce of Employee
- Spouse's Gain or Loss of Employment Other (Specify): _____
Which affects FSA coverage

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

I authorize the FSA account administrator to credit my Checking Savings _____ at _____
(Account Number) (Bank/Institution)

Routing number: _____ with my Flexible Spending Account payments. Please attach a copy of a voided check for account verification.

AUTHORIZATION (CHECK ONE)

- 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.
- I wish to discontinue my Flexible Spending Account salary reduction as indicated above.

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 after the Qualifying Event has occurred and only if the claim was incurred after the Qualifying Event.
- 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.