

**WAUKESHA COUNTY
HEALTH CARE REIMBURSEMENT ACCOUNT**
(Flexible Spending Account)

I. GENERAL INFORMATION

EMPLOYEE NAME: _____

MAILING ADDRESS: _____
 (STREET)

 (CITY) (STATE) (ZIP)

SOCIAL SECURITY #: _____ **DATE OF HIRE:** _____ **DATE OF BIRTH:** _____

II. HEALTH CARE REIMBURSEMENT FLEXIBLE SPENDING ACCOUNT

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year will be forfeited. Expenses/claims must be incurred during the Plan Year in order to be eligible for reimbursement.

FLEXIBLE SPENDING ACCOUNT - As a participant I hereby elect to participate in the Health Care Reimbursement FSA and therefore authorize my Employer to reduce my wages on a **pretax** basis during each payroll period in the following amount. I understand this election must be re-authorized each year.

	PER PAY PERIOD		# PAY PERIODS		ANNUAL ELECTION
HEALTH CARE REIMBURSEMENT	\$ _____	x	_____	=	\$ _____

The annual election cannot exceed \$2,550.00. The minimum amount is \$10.00 per pay period.

COVERAGE GOES INTO EFFECT ON THE FIRST DAY OF THE MONTH FOLLOWING 60 DAYS OF EMPLOYMENT.

Effective date of coverage: _____ The first payroll deduction will be on: _____

Pay schedule is biweekly.

III. AUTHORIZATION AND ACKNOWLEDGMENT

_____ I hereby elect to participate in the Health Care Reimbursement Flexible Spending Account.

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Status Change." The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket Medical, Dental, and/or Vision expenses before I can be reimbursed.

I understand that our plan provisions will require that all medical reimbursement participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options. If the continuation for the Health Care Reimbursement FSA is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

DATE _____ EMPLOYEE SIGNATURE _____

PLEASE RETURN THIS FORM TO WAUKESHA COUNTY HUMAN RESOURCES