



FSA Enrollment Form

Employer Name: Berkeley Unified School District

Last day of plan year: 12/31/2020

1 Employee Information - Please print clearly

FIRST NAME		LAST NAME		SOCIAL SECURITY NUMBER	
MAILING ADDRESS			CITY	STATE	ZIP CODE
DATE OF BIRTH	DAYTIME PHONE NUMBER		E-MAIL ADDRESS (Required)		

2 Make Your Elections - Enter your election for each account.

<p>Medical FSA</p> <p><input type="checkbox"/> I elect to participate in the Medical FSA. The amount I elect for the PLAN YEAR is (maximum <u>\$2,700</u>):</p> <p style="text-align: center;">\$ _____</p> <p>Your annual election will be deducted from your pay in equal installments throughout the plan year.</p>	<p>Dependent Care FSA</p> <p><input type="checkbox"/> I elect to participate in the Dependent Care FSA. The amount I elect for the PLAN YEAR is (maximum <u>\$5,000</u>):</p> <p style="text-align: center;">\$ _____</p> <p>Your annual election will be deducted from your pay in equal installments throughout the plan year.</p>
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3 *Your plan includes TWO initial Debit Cards at no cost to you. Debit cards are good for 3 years and are reloadable. The second Debit Card may be given to your Spouse or Adult Dependent to use, if applicable.*

4 Direct Deposit Authorization – Complete the banking information if you wish to establish direct deposit with BASIC pacific for your non-debit card reimbursements (or change your current direct deposit banking information on file).

By completing the banking information below, I hereby authorize BASIC pacific to deposit all non-debit card reimbursements directly into my personal bank account at the financial institution named below. I understand that I may cancel this authorization at any time by notifying BASIC pacific in writing. I further understand that I am responsible to notify BASIC pacific if, for any reason, my bank account information changes. If I do not sign up for Direct Deposit, I understand all non-debit card reimbursements will be paid to me by check.

Please Note: If you previously signed up for Direct Deposit with BASIC pacific, **you will continue** to be reimbursed for non-debit card expenses via direct deposit. If you wish to cancel your banking of record, please write **CANCEL** on the line below.

_____ Checking Savings

Name of DEPOSITORY (Name of Financial Institution)

Bank Routing Number _____ Account Number _____

5 *By checking the box below, you are agreeing to the terms and conditions printed on the back of this form*

I certify that I have read and agree to all the "Terms & Conditions for Participation in the Flexible Benefit Plan" printed on the back of this Election Form. I hereby authorize my employer to deduct the amounts listed above from my compensation.

EMPLOYEE SIGNATURE: _____ **DATE:** ____ / ____ / ____

6 To be completed by Employer

AUTHORIZED ER SIGNATURE	Select One Employee Paycycle: <input type="checkbox"/> M10/EOM-SKIP7/8 (CLS) <input type="checkbox"/> M10/EOM-SKIP7/8/12 (CRT) <input type="checkbox"/> M12/EOM (12) <input type="checkbox"/> M10/Special (15)	BENEFITS EFFECTIVE DATE (May not precede date employee signs) _____	Select One: <input type="checkbox"/> CERTIFICATED <input type="checkbox"/> CLASSIFIED	DATE OF HIRE: _____ DATE OF 1 ST PAYROLL DEDUCTION: _____
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Terms & Conditions for Participation in the Flexible Benefit Plan

I fully understand and agree that:

- I may never be reimbursed for expenses “incurred” (the date services are actually performed) prior to the later of, the date I am eligible to participate or the date I complete the enrollment form.
- Once made, my elections are “irrevocable” during the plan year unless I experience a “qualifying and related change in status”. I understand that I must refer to my SPD for details.
- If I am an active employee as of the last day of the plan year, I will forfeit any remaining balance left in my reimbursement account(s) unless BASIC pacific “receives” my claim for qualified expenses by the last day of my “run-out period”.
- If I terminate employment, or otherwise lose my eligibility to participate in the reimbursement accounts during the plan year, I may be required to submit claims for reimbursement shortly after losing my eligibility (refer to your SPD for the filing deadline if you terminate participation during the plan year). If I do not submit my claim for reimbursement by the deadline, I understand and agree that I will forfeit any remaining balance left in my reimbursement account(s).
- I may only receive reimbursements for qualified expenses incurred (date services are performed) during the plan year.
- I may be reimbursed for expenses incurred by myself, my spouse, my dependent children, and any other individual who qualifies as my federal tax dependent.
- I may not be reimbursed for expenses incurred by my domestic partner and/or their dependent children, unless my domestic partner and/or their children also qualify as my federal tax dependent(s).
- I may never seek reimbursement before an expense is “incurred” (performed).
- By participating in my flexible benefit (cafeteria) plan, I may reduce my Social Security tax contribution, and therefore, could potentially reduce my future social security benefits.
- My employer may modify or revoke my elections at any time if required to maintain the Plan in compliance with all applicable provisions of the Internal Revenue Code (IRC).
- This agreement is subject to the terms and conditions of the Plan and revokes any prior agreement I may have completed.
- I must make a new election each year (insurance premiums excepted). My FSA elections will not automatically roll-over.
- I am responsible to determine if the tax benefits provided by the Dependent Care FSA are superior to the federal tax credit.
- I am responsible to reimburse my employer for any benefits received, taxes, penalties or interest that may be imposed if I knowingly violate the terms of the Plan.
- I have received a Summary Plan Description (SPD) for the Flexible Benefit Plan.

Additional Debit Card Terms & Conditions

- I will only use my Debit Card for eligible expenses [including medical expenses as defined in Code § 213(d)]. In addition, certify that any expenses paid for with my Debit Card have not been reimbursed by any other source. In addition, I certify that I will not seek reimbursement for the same expense under any other plan.
- I will repay any Debit Card payment that has been declined by the Plan in a timely manner.
- I am fully responsible for the Debit Card activity of my spouse or other federal dependent for whom I have authorized to receive an additional Debit Card.