Boston College

Enrollment **Form – Flexible Spending Accounts**

PLAN YEAR January 1, 2017 – December 31, 2017

GENERAL INFORMATION:

Employee Name: _____ Eagle ID #: _ _ _ _ _ _ _ _ _

Mailing Address: _____

City:_____State: _____ Zip: _____

Date of Hire:_____ Email Address:_____

FLEXIBLE SPENDING ACCOUNTS:

I hearby elect to participate in one or both of the Flexible Spending Accounts as indicated below.

Health Care FSA **ANNUAL** election $_____ (minimum $100 & maximum $2,600)
(Medical, Dental & Vision expenses for you and your dependents)

Dependent Care FSA **ANNUAL** election $_____ (minimum $100 & maximum $5,000)
(E.g, Day care expenses incurred during employment hours for children age 12 and under)

Effective Date of Coverage_____(1st of the month following submission of this form)

My pay schedule is: ☐ weekly ☐ monthly
Check if you are paid fewer than 52 weeks or 12 months/year: ☐

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that my annual election may require adjustment to comply with IRS nondiscrimination guidelines. For the 2017 plan year, up to $500 (minimum $25) of unused funds in the Health Care FSA will automatically be "carried over" to the next calendar year**. I understand that any balance over $500 or under $25 will be forfeited.** The Dependent Care Account does NOT allow funds to be carried over**. Unused funds in the Dependent Care Account will be forfeited.** I have read and understand the rules and regulations on the reverse side of this form.

I certifiy that these expenses have not been and will not be reimbursed through any other means, including my or my dependent's insurance plans. I will repay funds in the event that I misuse the Health Care Debit Card, if applicable, to authorize payment for any non-eligible expenses, or fail to provide sufficient documentation within the stated time frame.

I understand that I cannot revoke or change this election unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care FSA may be limited.

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

My signature authorizes reductions from my pay checks for the purposes of funding my tax-free FSA account(s).

_____ _____
Employee Signature Date

_____ _____
Benefits Authorization Date

Please return this form to the Boston College Benefits Office
Brighton Campus, 129 Lake, Room 140

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

HEALTH CARE

ELIGIBLE EXPENSES:

In general, you may be reimbursed for a health care expense which is deductible for federal income tax purposes, but which has not and/or will not be reimbursed by any other source, and which has not been or will not be deducted on your income tax return. Some examples of eligible expenses include co-insurance and deductible amounts; vision, hearing, dental, and prescription drug expenses not covered by your health insurance.

INELIGIBLE EXPENSES:

Examples of ineligible expenses include insurance premiums; vitamins/supplements for general good health; cosmetic procedures, products and prescriptions; and counseling not related to a medical condition.

SUPPORTING DOCUMENTATION:

The following forms of supporting documentation may be attached to the reimbursement request form:

Expenses covered by your health care plan:

Medical and dental expenses covered by your health care plan must be submitted to that plan. You may attach the Explanation of Benefits Statement to the reimbursement request form for the portion of your claim not paid by your health care plan.

For all expenses, you must attach bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Nature of service or supplies (includes medication name)
3. Name and address of provider of services
4. Amount reimbursable under the plan
5. Date(s) service was rendered

DEPENDENT**

ELIGIBLE EXPENSES:

The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or $5,000, whichever is less. If you are married, filing separately, your annual reimbursement cannot exceed $2,500.

The expense must be employment-related and incurred for the care of your dependent who is age 12 or under and for whom you are entitled to a dependent deduction under Internal Revenue Code Section 151(c), or is your dependent who is physically or mentally incapable of caring for himself or herself, resides with you for more than ½ of the year, earns below $3,200 and will not be deducted or taken as tax credits on your federal and/or state income tax return for any year.

The payments cannot be made to a person who is claimed as a dependent by you.

Expenses for DAY camp programs are allowable; however, if camp hours exceed your working hours, submit ONLY that portion of expenses incurred for work- related hours. **OVERNIGHT CAMP is NOT an allowable expense**, even on a prorated basis.

SUPPORTING DOCUMENTATION:

For all expenses, you must attach bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Name and address of service provider
3. Nature of service
4. Amount reimbursable under the plan
5. Date service was rendered

Note: You will also need to submit the Provider's Tax ID Number when you file your federal income tax return for the year.

****QUALIFICATION GUIDELINES FOR A DEPENDENT CARE ACCOUNT**

To qualify, BOTH the employee and spouse must be working, or one working and the other enrolled as a full-time student, or actively looking for work. If the employee is single, divorced or legally separated, the employee's need for dependent care assistance must be work related.

PLEASE NOTE

Service dates for reimbursable expenses must fall within the plan year.. Reimbursement requests not submitted during the plan year must be submitted prior to the end of the 3-month run out period. Please contact your Benefits Office or WageWorks for more information.

For additional information or questions, please visit **www.wageworks.com** or contact WageWorks Customer Service at 877-924-3967 Monday through Friday, from 8 a.m. to 8 p.m. EST.