



# Flexible Spending Accounts

Bank on a Tax Break



# Health Care Flexible Spending Account (FSA)

## Contributions

You determine each year how much money you want to contribute to a Health Care FSA through salary reduction. Your taxable salary will be reduced by the amount of money you elect to contribute each pay period. If you terminate employment and have an account balance you may be eligible to continue your coverage under the Health Care FSA by making after-tax contributions to the plan.

You may only change your election **DURING** the plan year if you experience a "permitted change in status event" as described in your Summary Plan Description - otherwise you may only change your election during the Open Enrollment period.

## • Expenses and Reimbursements

You will be reimbursed for incurred health care expenses up to the total amount of money you elect to contribute for the entire plan year. For example: if you elect to contribute \$1,200 for the year (\$100 per month) and incur an expense of \$1,200 in the first month of the plan year, you will be reimbursed \$1,200 when you submit your claim.

You will be reimbursed for health care expenses that are *INCURRED during the plan year and during a period when you are contributing to the Health Care FSA*. The date the expense is incurred is the date you (or your family member) received the health care service. The date you are billed for the service or the date you paid for the service is not the date an expense is incurred.

Expenses eligible for reimbursement from a Health Care FSA are generally medical expenses that can be deducted on a federal income tax return. These expenses can be for you, your spouse or your dependents. Dependents generally include any family member eligible to be claimed on your taxes.

## • Eligible Receipts

All receipts must indicate the name of the service provider/merchant, original date of service, the type of service/purchase made, and the amount charged. Simple debit card receipts and cancelled checks are not acceptable receipts in accordance with IRS guidelines.

## • Examples of Expenses Eligible for Reimbursement from a Health Care FSA:

|                             |                          |                   |
|-----------------------------|--------------------------|-------------------|
| Co-Insurance                | Diabetic Supplies        | Laser Eye Surgery |
| Co-Pays                     | Eye Exams and Eyeglasses | Orthodontia       |
| Deductibles                 | First Aid Supplies       | Wheelchairs       |
| Dental expenses (qualified) | Insulin                  | Walkers and Canes |

## • Forfeitures

The Internal Revenue Service requires that you forfeit any money left in your Health Care FSA at the end of the plan year. Therefore, it is very important to determine prior to your participation in the plan how much money you want to contribute to the Health Care FSA.

## Flexible Spending Account Tax Savings Comparison

Your employer makes it possible for you to "Bank on a Tax Break" by allowing you to participate in a Flexible Spending Account Plan. This plan allows you to contribute to a Health Care and/or a Dependent Care Flexible Spending Account (FSA). Your FSA contributions are made each pay period before federal, state and FICA taxes are deducted. As you incur eligible expenses you will be able to receive tax-free reimbursement.

Let's look at how contributing to a Flexible Spending Account could affect your paycheck and save taxes.

An employee earns \$2,500 per month and incurs the following monthly expenses:

Family Medical Expenses (deductible, dental, vision, etc.): \$100/month  
 Dependent Care Expenses (daycare, summer day camp, etc.): \$400/month

Contributions to Flexible Spending Accounts: \$500/month

|  | Without FSA | With FSA |
|--|-------------|----------|
| Gross Monthly Salary:                  | \$ 2,500    | \$ 2,500 |
| Less Pre-Tax Medical Expense:          | \$ 0        | \$ 100   |
| Less Pre-Tax Dependent Care Expense:   | \$ 0        | \$ 400   |
| Adjusted Taxable Salary:               | \$ 2,500    | \$ 2,000 |
| Less Federal Tax:                      | \$ 375      | \$ 300   |
| Less State Tax:                        | \$ 175      | \$ 140   |
| Less FICA Tax:                         | \$ 191      | \$ 153   |
| Less After-Tax Medical Expense:        | \$ 100      | \$ 0     |
| Less After-Tax Dependent Care Expense: | \$ 400      | \$ 0     |
| Monthly Spendable Income:              | \$ 1,259    | \$ 1,407 |

By taking advantage of both Flexible Spending Accounts this employee is able to increase spendable income by \$148 per month for annual tax savings of \$1,776.

## Flexible Spending Account (FSA) Worksheet

Use the worksheet below to determine what you and your family expect in out-of-pocket expenses that will not be reimbursed or covered by any other health or dental insurance plan. Only estimate expenses you expect to incur during the plan year.

### Dependent Care Expenses (for Dependent Care FSA)

Babysitting / Day Care / Elder Care Expenses: \_\_\_\_\_ After-School Fees: \_\_\_\_\_  
 Nursery School Fees: \_\_\_\_\_ Summer Day Camp: \_\_\_\_\_

Total Dependent Care Expenses \_\_\_\_\_

### Health Care Expenses (for Health Care FSA)

Medical Deductibles, Co-insurance, Co-payments: \_\_\_\_\_ Dental Expenses: \_\_\_\_\_  
 Eyeglasses, Contact Lenses, Vision Exams: \_\_\_\_\_ Prescription Drugs: \_\_\_\_\_  
 Other Eligible Expenses: \_\_\_\_\_

Total Health Care Expenses \_\_\_\_\_

**MYFLEXONLINE**—A portal to access your personal Flexible Spending Account online.

Once the plan year begins, participant information can be viewed by accessing [www.myflexonline.com](http://www.myflexonline.com).

- Election information will not appear on [www.myflexonline.com](http://www.myflexonline.com) until after the first day of the new plan year
- Myflexonline allows a participant to view paid and pending claims as well as their account balance. Claim forms can be created and printed for reimbursement (with applicable receipts)

# Dependent Care Flexible Spending Account (FSA)

## Contributions

You determine each year how much money you want to contribute to a Dependent Care FSA through salary reduction. Your taxable salary will be reduced by the amount of money you elect to contribute each pay period. You may only change your election **DURING** the plan year if you experience a "permitted change in status event" as described in your Summary Plan Description - otherwise you may only change your election during the Open Enrollment period.

## Expenses and Reimbursements

You will be reimbursed for incurred dependent care expenses up to the total amount of money credited to your account. For example, if you elect to contribute \$1,200 for the year (\$100 per month) and incur an expense of \$500 in the first month of the plan year, you will be reimbursed \$100 when you submit your claim. The remaining excess expense will be carried over to the succeeding month(s) of the plan year.

You will be reimbursed for dependent care expenses incurred during the plan year. The date the expense is incurred is the date you (or your family member) received the dependent care service. The date you are billed for a dependent care service or the date you paid for a dependent care service is not the date an expense is incurred.

Dependent care expenses must be for the care of a dependent under the age of 13, or if over the age of 13, the dependent must be mentally or physically incapable of self-care. Dependent care expenses must allow you (and if married, your spouse) to work.

- **Expenses Eligible for Reimbursement:**

Au Pair Expenses  
Day Care Center Expenses

Babysitter Expenses  
Preschool Tuition

Before & After School Expenses  
Summer Day Camp Expenses

- **Expenses NOT Eligible for Reimbursement:**

Educational Expenses  
Overnight Camps

Non-Work Related Expenses  
Expenses Paid to a Dependent Child

Kindergarten/Higher Grade Tuition  
Daycare Meals/Supplies

- **Eligible Receipts**

All receipts must indicate the name of the service provider, original date of service, the type of service, and the amount charged, or the Dependent Care provider can sign the claim form. Simple debit card receipts and cancelled check are not acceptable in accordance with IRS guidelines.

- **Choosing Between a Dependent Care FSA and the Dependent Care Tax Credit**

You should determine which is better, the Dependent Care Tax Credit or the Dependent Care FSA, or a combination of both. Consult your tax advisor for more information.

## Forfeitures

The Internal Revenue Service requires that you forfeit any money left in your Dependent Care FSA at the end of the plan year. Therefore, it is very important to determine prior to your participation in the plan how much money you want to contribute to the Dependent Care FSA.



# CBIZ Flex

## Flexible Benefits Plan Election Form

Version 08.11.10

|                              |  |  |                      |
|------------------------------|--|--|----------------------|
| <b>Employer:</b>             |  |  |                      |
| <b>Employee:</b>             |  |  |                      |
| <b>SSN:</b>                  | <input type="text"/>   | <input type="text"/>                         | <input type="text"/> |
| <b>Address:</b>              |  |  |                      |
| <b>City:</b>                 | <input type="text"/>   | <b>State</b>                                 | <input type="text"/> |
|                              | <input type="checkbox"/> <i>Check here to indicate an address change</i> | <b>Zip</b>                                   | <input type="text"/> |
| <b>Date of Hire:</b>         | <input type="text"/>   | <b>Date of Birth:</b>                        | <input type="text"/> |
| <b>Email:</b>                |  |  |                      |
| <b>Effective Date:</b>       |  |  |                      |
| <b>Pay Periods Per Year:</b> | <input type="checkbox"/> Weekly (52 pays)                                | <input type="checkbox"/> Bi-Weekly (26 pays) |                      |
|                              | <input type="checkbox"/> Semi-Monthly (24 pays)                          | <input type="checkbox"/> Monthly (12 pays)   |                      |

| New Flexible Spending Account Elections  |                |                 |
|--|----------------|-----------------|
|  | Per Pay Period | Plan Year Total |
| Health Flexible Spending Account         |                |                 |
| Dependent Care Flexible Spending Account |                |                 |
| Limited Flexible Spending Account        |                |                 |
| Parking                                  |                |                 |
| Transit                                  |                |                 |
| Other:                                   |                |                 |
| Other:                                   |                |                 |
| <b>Total Reduction Amount</b>            |                |                 |

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (marriage, divorce, death of Spouse or child, birth or adoption of a child, and termination of employment of Spouse.) I understand that insurance claim payments under certain coverage may be subject to Federal and State taxes when the premium is paid by salary reductions or employer contributions. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must be completed.

**Authorization:** I certify the above information to be correct and true and any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and/or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I hereby authorize the deduction of the administrative fee, if applicable. The plan administrator may revoke or reduce any election to prevent the Plan from becoming discriminatory within meaning of IRC Section 125 and/or any other regulation

If Section 132(f) is offered by Company: I understand that my cash compensation will be reduced by amounts equal to my contribution for the qualified parking and transit expenses for my employer-sponsored Section 132(f) benefit as stated above and if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect due to changing facility parking expenses, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

This agreement is subject to the terms of the Company's Section 132(f) Qualified Transportation Fringe Benefit provisions (if offered), as amended from time to time and shall be governed by and construed in accordance with applicable laws and revokes any prior election and compensation reduction agreement relating to such benefit(s). My signature indicates that I have read and understand the Terms and Conditions (included with this form).

Accept                       Decline

\_\_\_\_\_    \_\_\_\_\_  
Signature    Date

**Please return this completed form to your Payroll or Human Resources personnel.**



**CBIZ Flex**  
**Agreement for Employee Direct Deposit**  
*Version 08.11.10*

|                      |  |
|----------------------|--|
| <b>Company Name:</b> |  |
|----------------------|--|

This authority will remain in full force and effect until CBIZ Payroll has received written notification from me of its termination in such time and in such manner as to afford CBIZ Payroll a reasonable opportunity to act on it. CBIZ Payroll is not responsible for any bank fees related to expenditures made before an actual ACH Deposit is in my account. It will be my responsibility to verify that the funds are in my account before I expend them.

*Please note: Before the Direct Deposit option takes effect, a prenotification transaction will be sent to the bank for approval, therefore the next disbursement after this election will still come in the form of a check. Remaining payments will then be made via Direct Deposit. Any Direct Deposit transactions stopped by the bank will cancel your ACH election until corrections can be made.*

|                                       |                                   |                                  |       |
|---------------------------------------|-----------------------------------|----------------------------------|-------|
| Employee ID                           | _____                             |                                  |       |
| Institution Name                      | _____                             |                                  |       |
| Routing #                             | _____                             | Account #                        | _____ |
| Account Type                          | <input type="checkbox"/> Checking | <input type="checkbox"/> Savings |       |
| Employee Name                         | _____                             |                                  |       |
| Employee Signature                    | _____                             |                                  |       |
| Co-Owners Name                        | _____                             |                                  |       |
| Co-Owners Signature<br>(Not Required) | _____                             |                                  |       |

**Fax or mail completed form:**  
CBIZ Payroll, Attn: Flex  
310 First St., Ste 600  
Roanoke, VA 24011  
Fax: **800-584-4185** Phone: 800-815-3023 option 4 Email: [cbizflex@cbiz.com](mailto:cbizflex@cbiz.com)

|                    |                   |
|--------------------|-------------------|
| CBIZ Flex Use Only | Company ID: _____ |
|--------------------|-------------------|