MOUNT HOLYOKE
MOUNT HOLYOKE COLLEGE

Enrollment Form for Flexible Spending Accounts

Plan Year July 1, 2022 - June 30, 2023

Last Name:	First Name, Middle Initial:
Phone / Cell Phone:	Email:
Department:	Pay Frequency: *Monthly*_____ *Biweekly*_____
Did you sign up for Flex (at MHC) in 2017: *Yes*____ *No*___	FSA Start Date:
If your appointment/contract is ending in 2018, please write the expected end date :	

The amount you enter as your "Contribution" multiplied by the number of "Pay periods" (checks you receive in a year) needs to equal the total annual contribution. ***Example:***

$19.25	26	$500.50
Contribution	Pay Periods (number of checks)	Annually

Health Care Spending Account (For medical expenses only) Plan: FSAM

❒ I elect to contribute:

$ _____ (Contribution) X _____ (Pay Periods (number of checks)) = _____ annually (min: $**120**, max: $**2850**)

Dependent Care Spending Account Plan: FSAD

❒ I elect to contribute:

$ _____ (Contribution) X _____ (Pay Periods (number of checks)) = _____ annually (min: $**120**, max: $**5000**)

I have read and understand the enrollment materials explaining the Spending Accounts. I understand that:

- Any contributions I make to a Health Care Spending Account and/or Dependent Care Spending Account will reduce my taxable income for purposes of Federal Income, State Income and Social Security taxes;
- The amount I have chosen to contribute for the reimbursement of health care and/or dependent care expenses can be used only for the purposes set forth in the plan description;
- I cannot change or revoke this agreement during the plan year unless I have a Qualified Status Event Change;
- Any unused funds remaining in my Dependent Care account will be forfeited after Sept 15th following the end of the plan year.

In order for a medical and/or dependent care expense to be considered a reimbursable **"eligible expense"** during the 2022-2023 plan year, the medical and/or dependent care services related to that expense must be performed and/or provided within the plan year (July 1, 2022 - June 30, 2023), or in the case of a new employee hired after the start of the plan year, that portion of the plan year in which the employee participates.

*If you are signing up for Flexible Spending Account for the **first time**, our vendor will contact you to request information for Direct Deposit for reimbursements.*

Employee's Signature Date

Mount Holyoke College Representative Date

MOUNT HOLYOKE COLLEGE

In signing the reverse of this form, I understand and agree to the following:

The College and I hereby agree that my cash compensation will be reduced by the amounts I have elected on this form on a per pay-period basis during the plan year (or during such portion of the year as remains after the date of this agreement).

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE COLLEGE'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a status change event (including marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, change in job schedule of participant or spouse, dependent satisfying or ceasing to satisfy dependent eligibility requirements, entitlement to Medicare or Medicaid, judgment, decree or court order or such other events as the Plan Administrator determines will permit a change or revocation of an election).

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

The amount of my compensation reduction during the year will be credited to an insurance, medical reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed for qualified expenses incurred during the plan year. If I terminate employment, I will only be reimbursed for expenses incurred prior to my termination date unless I qualify for, and elect COBRA coverage.

My Social Security benefits may be slightly reduced as a result of reduced taxable income due to my election(s).

If required contributions for elected benefits are increased or decreased while this agreement remains in effect, the compensation reduction will automatically be adjusted to reflect that increase or decrease.

Health Flexible Spending Account (FSA) will be available only for "qualifying medical care expenses" which are those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e., premiums for health insurance cannot be reimbursed from your Health FSA). I agree to notify the College if there is reason to believe that any expense for which reimbursement has been obtained is not a qualifying expense. I also agree to indemnify and reimburse the College on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

Dependent Care Assistance Plan (DCAP) will be available only for "qualifying dependent care expenses" as described below. I agree to notify the College if there is reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense, I also agree to indemnify and reimburse the College on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.
I agree to provide the Plan Administrator with the name, address, and taxpayer identification number of each dependent care service provider.

Qualifying Dependent Care Expenses:
1. The expenses are incurred for services rendered after the date of this election and during the plan-year to which it applies.
2. Each individual for whom you incur the expenses is (a) a dependent under the age 13 whom you are entitled to claim as a dependent* on your federal income tax return or (b) a spouse or other tax dependent* who is physically or mentally incapable of caring for himself or herself.
*or a child or other dependent under age 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2(a) above, or who regularly spends at least 8 hours a day in your household.
5. The expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the Facility), which complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom you or your spouse are entitled to a personal tax exemption.
8. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the least of the following limits: (a) The maximum allowed under the Plan. (b) $5,000 if you are filing a joint tax return or $2500 if separate returns are filed. (c) Your taxable compensation (after all compensation reduction elections). (d) If you are arried, your spouse's actual or deemed earned income.
This agreement will automatically terminate if the Plan is terminated or discontinued.