

**JAMES CITY COUNTY GOVERNMENT
FLEXIBLE BENEFIT PLAN
SALARY ADJUSTMENT AFFIDAVIT
JULY 1, 2016 – JUNE 30, 2017**

DEDUCTION EFFECTIVE _____

I, _____, Employee # _____
(Please Print)

*Mailing Address (including city, state, and zip code)

Work Phone # _____

Home Phone # _____

an employee of the employer noted above, do hereby elect to participate in my employer's Flexible Benefit Plan and to be reimbursed for the expenditures indicated below, all of which I will incur during the above Plan Year. Each of the declared amounts indicated below are reimbursements and satisfy the requirements under the Flexible Benefit Plan as described in the employer Plan Document.

I hereby authorize my employer to reduce my gross compensation each SEMI-MONTHLY pay period by an amount equal to the total of these expenditures. (24)
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	<u>Per Pay Period</u>	<u>Annual Election</u>
HEALTH CARE REIMBURSEMENT ACCOUNT (Qualified unreimbursed health care expenses) Max. Annual Election: \$2,550.00	\$ _____	\$ _____
DEPENDENT CARE REIMBURSEMENT ACCOUNT (Qualified child care and dependent care expenses) Max. Annual Election: \$5,000.00	\$ _____	\$ _____
TOTAL	\$ _____	\$ _____

Treatment of Unused Declarations

If, at the end of the Plan Year, the total of my declared reduction in compensation exceeds my substantiated incurred expenses, I recognize that the difference in the amounts will be forfeited. I further acknowledge that the above listed amounts shall be irrevocable until the beginning of the next Plan Year unless there is a material change in my family situation of a nature permitting a mid-year change under IRS regulations.

BENEFITS CARD ELECTION

- | |
|--|
| <input type="checkbox"/> I do NOT elect to use the Benefits Card
<input type="checkbox"/> I elect to be issued a Benefits Card
<input type="checkbox"/> I would like to have a second card issued to my dependent, whose name and social security number are indicated below: |
|--|

Dependent Name

Dependent Social Security Number

Benefits Card Certification

I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my BENEFITS CARD. I certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the Plan administrator, provide required documentation of expenses.

AUTHORIZATION FOR CLAIMS COMMUNICATION TO BE SENT VIA EMAIL

I authorize Flexible Benefit Administrators, Inc. to send me information regarding my claims via email. I understand that I will no longer receive claims communication via U.S. mail to my home address.

It is also my responsibility to notify Flexible Benefit Administrators, Inc. if this information should change or if I elect to stop correspondence via email.

EMPLOYEE NAME

EMAIL ADDRESS

HOME TELEPHONE NUMBER

SIGNATURE

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (CREDITS)

I hereby authorize **FLEXIBLE BENEFIT ADMINISTRATORS, INC.**, hereinafter called **ADMINISTRATOR**, to initiate credit entries to my

_____ **checking** **savings**
(name of bank)

account indicated below and the depository named below, hereinafter called **DEPOSITORY**, to credit the same to such account. I also authorize the **ADMINISTRATOR** to draw drafts on my account or to initiate debit entries to my account, for the purpose of withdrawing money from my account, but solely in order to adjust an error resulting from a deposit or credit entry that has been made under this Authorization in an amount that is not correct. The **DEPOSITORY** shall not be liable for honoring any draft, debit entry or withdrawal initiated by the **ADMINISTRATOR**.

Depository Name	Office
Bank Transit/ABA Number:	Account Number:

This authority is to remain in full force and effect until termination from the Plan or notification in writing by the participant.

EMPLOYEE NAME

EMPLOYEE NUMBER

DATE

SIGNATURE

NOTE: FOR NEW ACCOUNTS, PLEASE ATTACH A VOIDED CHECK TO THIS AUTHORIZATION AGREEMENT.

I hereby certify that I have examined this Salary Adjustment Affidavit and to the best of my knowledge and belief, it is true, correct, and complete.

DATE

SIGNATURE

WITNESS



Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

Direct Deposit Form

(Please complete this form if you are a new FBA participant or if your bank account information has changed in the past year. You don't need to complete this form if you had direct deposit in the last year and your bank account information hasn't changed.)

Employee Information

Employee Name: Social Security # or Employee ID:

Home Telephone: Alternate Telephone (work/cell):

Address:

City: State: Zip:

Email: Name of Employer:

Help us go green! If provided, we will use your email as our primary method of contact.

Bank Account Information

Bank Name: Checking Account*
 Savings Account**

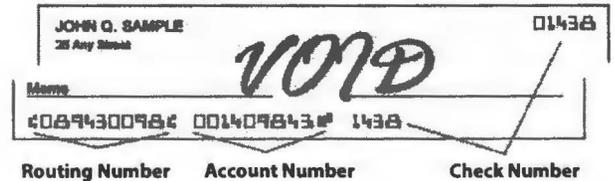
Bank Address:

City: State: Zip:

Name on the Account:

Routing Number:

Account Number:



*Please provide a voided check, we will not process without a voided check.

**Please provide a copy of your Savings account deposit slip.

Authorization

I authorize reimbursements from my Section 125 FSA, Dependent FSA, Individual Health Premium, Limited Purpose FSA, or my Section 105 Health Reimbursement Arrangement to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my account, I authorize my Section 125/105/132 administrator to debit my account(s) not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

Signature: Date:

Please fax, email, or mail completed form with a voided check to:

Fax: 757-431-1155 Email: FlexDivision@flex-admin.com

Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA 23450

Print Form



Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

Benefits Card Election Form

Employee Information

Social Security # or Employee ID: Date of Birth:

Employer Name:

First Name: Middle Initial: Last Name:

Employee Home Address:

City: State: Zip:

Home Phone #: E-Mail:

Help us go green! If provided, we will use your email as our primary method of contact.

Employee Elections

Cards are valid for 3 years from date of issue.

My Card

- I do NOT elect to use the Benefit Card. All cards from previous years will be deactivated.
- I am a New Participant and I elect to be issued a Benefits Card.
- My card has been lost/destroyed. Please re-issue a new Benefits Card.

Dependent Card

Dependent SSN Date Of Birth
Print name Social Security Number

Dependent SSN Date Of Birth
Print name Social Security Number

Dependent SSN Date Of Birth
Print name Social Security Number

- I would like to have a second card issued to my dependent, who's over the age of 18, who's name and social security number are indicated above.
- My dependent's card has been lost/destroyed. Please issue a new card to the dependent above.
- Please deactivate my dependent's card(s).

*** Benefit Cards are automatically re-issued upon expiration and are pre funded with your health care annual election amount. Dependent care annual elections are not pre funded.***

Benefits Card Certification

I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my BENEFITS CARD and certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the Plan administrator, provide required documentation of expenses.

Failure to submit sufficient documentation for your Benefit Card transaction may result in deactivation of your card.

Employee's Signature: Date: