

FLORIDA FLEXIBLE SPENDING ACCOUNTS

“Making Your Money Work for You”



DEPARTMENT OF MANAGEMENT SERVICES
DIVISION OF STATE GROUP INSURANCE (DSGI)

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INTRODUCTION TO FLEXIBLE SPENDING

The Flexible Spending Accounts Program (FSA) is qualified under Section 125 of the Internal Revenue Code established by the U.S. Congress in the Revenue Act of 1978.

Flexible Spending Accounts let you “stretch your dollars” three ways:

- You can pay your State Group Health, Life, and certain Supplemental plans' insurance premiums on a pretax basis. Pretax means your premiums are paid **before** your federal income tax and FICA (Social Security) taxes are calculated.
- You can establish a pretax deduction for a Medical Reimbursement Account (MRA) to reimburse you for certain eligible out-of-pocket medical expenses.
- You can establish a pretax deduction for a Dependent Care (DC) Reimbursement Account to reimburse you for eligible dependent care expenses.

As a State employee, you may take advantage of **any or all** of the above benefits offered under the pretax program.

The Plan Year for the FSA runs from January 1 through December 31. Participation in any component of the Plan **cannot be changed or canceled** during the Plan Year unless you experience a specific “qualifying status change” event. (Refer to the section called “**Qualifying Status Changes**” on page 12 for more information.)

FLEXIBLE SPENDING ACCOUNTS PROGRAM

SAMPLE SALARY COMPARISON

See How Much You May Save With The Flexible Spending Accounts Program

Mr. Smith earns an annual salary of \$31,000 and pays for family insurance coverage under the State Group Health Insurance Program. His State Health Insurance premiums are pretaxed. Mr. Smith has designated \$2,000 annually (\$166.67 per month) to a Dependent Care (DC) Reimbursement Account.

The \$166.67 monthly contribution for dependent care expenses will be returned on a tax-free basis when Mr. Smith incurs eligible expenses and files claims.

Result: Mr. Smith has increased his spendable income \$769 per year by electing to participate in two of the three benefit options available under the Flexible Spending Accounts Program.

Exemption - \$2,750
Standard Deduction - \$7,200
FICA - 7.65%
Withholding - 15%

*Figures were calculated based on 1999 tax rates, married filing jointly, with two exemptions.

Annual Savings Illustration

Annual Salary	\$ 31,000
Annual Insurance Premiums	1,394
Dependent Care Expenses	2,000

	Without Plan	With Plan
Gross Pay	\$ 31,000.00	\$ 31,000.00
Pretaxed Premiums	-	(1,394.00)
Pretaxed Deductions	-	(2,000.00)
Taxable Gross	31,000.00	27,606.00
FICA	(2,371.50)	(2,111.86)
Withholding	(2,745.00)	(2,235.90)
Net Pay	25,883.50	23,258.24
Non-Pretaxed Premiums (after net pay)	(1,394.00)	-
Dependent Care Expenses	(2,000.00)	-
Spendable Income	\$ 22,489.50	\$ 23,258.24
Savings	-	\$769

HOW PRETAX PREMIUMS WORK FOR YOU

When You Participate

When you choose to pay your State Group Health, Life, and certain Supplemental Insurance premiums through the Pretax Premium Plan component, your premiums are deducted from your salary before federal income taxes and Social Security taxes are calculated. You save money by not paying taxes on the portion of your salary that pays insurance premiums! The example on page 3 illustrates how the Pretax Premium Component can work for you.

You will automatically participate in the Pretax Premium Component of the Flexible Spending Accounts Program when you enroll and pay premiums for either State Group Health, Basic Life, and/or certain Supplemental Insurance Plans.

The worksheet on page 14 will give you an estimate of the tax savings you may enjoy when your premiums are pretaxed. If you have any questions on which is better for you - taxed or pretaxed - consult a tax advisor or local Internal Revenue Service office.

When You Don't Participate

If you choose not to participate in the Pretax Premium Component, you are still able to obtain State Group Health and Life Insurances and the premiums will be taxed as part of your income. To opt out of this pretax option you must complete and return a Pretax Premium Waiver Form (FB-1) available from your agency's personnel office. A waiver has to be completed during your initial 60 days of employment with the State AND during EACH annual Open Enrollment period to be excluded from this benefit.

Pretax Supplemental Plans of Insurance

The Florida Legislature passed legislation that would allow the pretax treatment for premiums of certain supplemental plans of insurance. The plans included in this program are as follows:

- **Supplemental Health Insurance** - Plans provided by Alta and Philadelphia American Life Insurance Company (through the Gabor Agency).
- **Supplemental Cancer / Intensive Care** - plans provided by American Family Life Assurance Company (AFLAC) and Colonial Life and Accident Insurance Company.
- **Supplemental Dental and Vision Insurance** - American Dental Plan, CIGNA Dental, Denticare, Oral Health Services and VisionCare.
- **Supplemental Accident / Disability** - plan provided by Colonial Life and Accident Insurance Company.

Since these plans are available on a pretax basis only, you may not waive the pretax treatment of premiums.

IMPORTANT: As a participant in the Pretax Premium Component of the FSA, you will be allowed to make changes to your health, life insurance or supplemental coverage only if a "Qualifying Status Change" event has been experienced and you request a change within 31 days of the event. For more information on Qualifying Status Change events, see page 12.

REIMBURSEMENT ACCOUNTS

Who is Eligible?

All full-time and part-time employees filling established positions are entitled to participate in Medical and/or Dependent Care Reimbursement Accounts. Employees who do not fill established positions (e.g., OPS employees) are not eligible. If you are not sure of your eligibility status, check with your Agency Personnel Office or the Division of State Group Insurance (DSGI).

How Reimbursement Accounts Work

Reimbursement accounts can provide you a way to pay for eligible out-of-pocket medical and/or dependent care expenses with tax free dollars. During each Open Enrollment period, you may elect an annual amount to put aside into a reimbursement account based on what you expect to incur for eligible medical and/or dependent care expenses. The amount you designate will be deducted from your salary throughout the Plan Year.

Then, as you incur expenses you submit claims to DSGI along with documentation of the expense for reimbursement.

After your claim is processed, the State issues a reimbursement check payable to you from the funds in your reimbursement account. (For medical expenses, reimbursement can be made up to your annual election amount at any time and is not based on deposit amounts.)

The result is that your expenses are reimbursed to you with money that is not taxed, and your spendable income is increased.

Medical Reimbursement Accounts

Many medical expenses are deductible from your income by itemizing them on your federal income tax return. Tax laws permit medical expenses that exceed 7.5% of your adjusted gross income to be deductible. Since most of us do not have enough medical expenses to exceed the 7.5% level, this is where a Medical Reimbursement Account (MRA) can help.

While many medical expenses are difficult to foresee, based on your family size and past expenses, you can make a prediction as to how much expense you will have during the upcoming year. The MRA worksheet on page 15 makes it easy to assess your expense history and will assist you in determining how much your annual election should be. **The Plan advises that you be conservative in your election amount due to the forfeiture rules that exist.** Please be sure to read the “Use It or Lose It” explanation on page 10.

The minimum annual election for the Medical Reimbursement Account is \$60 and the maximum is \$2,400 for the Plan Year.

The following pages list expenses that are eligible and ineligible for reimbursement from the Plan. Retain these pages in case you have questions regarding the eligibility of expenses during the year.

FLEXIBLE SPENDING ACCOUNTS PROGRAM

Eligible Health Care Expenses

You may use your Medical Reimbursement Account (MRA) to reimburse yourself for the following health care expenses incurred during the year:

- deductible amounts you pay under your health care insurance plan or under your spouse's plan
- the portion of covered expenses that you have to pay (called a co-payment), including HMO co-payments, for medical bills after you have met your deductibles
- any amounts that you are required to pay after the maximum benefit under a health care plan has been paid
- other health care expenses not covered by an insurance plan that otherwise would be eligible for deduction when you file your tax return. These can include expenses for:
 - acupuncture
 - air conditioning (only if medically related)
 - alcoholism treatment
 - ambulance services
 - anesthetist
 - animal trained to aid visually impaired (seeing-eye dogs)
 - artificial limbs
 - Braille books & magazines
 - chiropodists
 - chiropractors
 - Christian Science practitioners
 - contact lenses & supplies (no cash register receipts)
 - contraceptive devices (prescription)
 - co-payments and deductibles not covered by medical or dental insurance
 - cosmetic surgery (**only if it corrects a congenital deformity or disfigurement due to an accident or disease**)
 - crutches
 - dental fees (if not cosmetic)
 - dentures
 - dermatologists (if not cosmetic)
 - drug addiction therapy
 - electrolysis (only in relation to a medical condition)
 - eye examinations & eye glasses
 - hearing aids
 - hospital fees
 - insulin
 - legal abortions
 - mileage (@ 12 cents per mile)
 - nursing home (medical portion only)
 - nursing services
 - obstetricians (only for services that actually have been performed during the plan year)
 - occupational therapy
 - ophthalmologists
 - optician
 - optometrists
 - orthodontia (only for services described on page 7)
 - orthopedic shoes
 - orthopedists
 - osteopaths
 - oxygen
 - patterning exercise given to retarded children
 - pediatrician
 - physician's fee
 - physiotherapist
 - podiatrists
 - prenatal care
 - eligible prescription drugs
 - programs to stop smoking
 - psychologists
 - psychotherapy
 - sanitarium stays
 - special home for mentally disabled
 - eligible surgical fees (not cosmetic)
 - telephone (specifically equipped for hearing impaired)
 - transplants
 - tuition at special school for disabled
 - vaccines
 - vasectomy
 - wheel chair
 - x-ray fees

For these expenses to be eligible, they must be considered medically necessary and prescribed by your physician.

* All the above services must be rendered for reimbursement to be made.

Ineligible Health Care Expenses

Medical and dental premiums cannot be reimbursed through this account. In addition, elective cosmetic surgery and similar expenses are not allowable expenses according to Internal Revenue Provisions. Other common ineligible expenses include:

- anti-baldness drugs
- cost of dancing or swimming lessons, even if recommended by your doctor
- dental procedures to whiten your teeth (bleaching)
- diaper service
- electrolysis
- expenses for trips, even for general health improvement
- health club dues
- household help
- insurance premiums
- illegal operations and treatment
- medicines purchased over the counter, even if prescribed
- maternity clothes
- non-prescription drugs
- toothpaste, cosmetics, and toiletries
- weight loss programs and appetite suppressants

ORTHODONTIC AND OBSTETRIC EXPENSE CLAIMS REIMBURSEMENT POLICY GUIDE

Orthodontic

Available reimbursement methods for orthodontic expenses are as follows:

- the amount paid to the dentist or orthodontist can be reimbursed from your account with the submission of proper statement(s) or receipt(s).
- a copy of the orthodontic contract is submitted prior to or with the first reimbursement.

Obstetrics

Available reimbursement methods for obstetric expenses are as follows:

- the amount billed for procedures performed during the term of the pregnancy may be reimbursed. Outstanding expenses may be reimbursed upon final billing after the child's delivery.
- Lump sum payment after delivery.

Terminations

If you participate in a Medical Reimbursement Account and terminate your State employment, you must complete a Medical Reimbursement Account Termination of Employment Form (FB-4) page 30.

Forms are available from your agency personnel office. If you terminate participation in the Plan, claims for medical expenses incurred after your termination will not be eligible for reimbursement.

NOTE: One option on the FB-4 Form is to have your balance deducted from your annual or sick leave on a pretax basis. This option will allow you to be reimbursed for expenses incurred through the end of the plan year.

However, should contributions to your account stop for any reason, payment of claims will be suspended, regardless of account balance. For participants who have terminated, claim payments will be suspended until the FSA Section receives a signed FB-4 Form with selection and payment. Participants going on leave must contact their Personnel Office for existing options.

Dependent Care Reimbursement Account

If you have dependent children, a disabled or elderly dependent, you know how dependent care fees can take a substantial portion of your salary. Fortunately, these expenses are fairly predictable. It is easy to calculate the election for your Dependent Care Reimbursement Account. However, careful planning is still necessary to avoid forfeiture of unused money at the end of the Plan Year. (See “Use It or Lose It” on page 10.)

If you establish a Dependent Care Reimbursement Account, you cannot take advantage of the federal child care tax credit for the same expenses. You should complete the worksheet on pages 16 - 18 to determine whether you will save more on taxes by using a Dependent Care Account or the child care tax credit; each case can be different. If you have any questions on which is better for you, consult your tax advisor or your local IRS office.

The maximum you can contribute to your Dependent Care Account is \$5,000 during any calendar year (or \$2,500 if married filing separately). The minimum you can designate is \$60 per year. You may not contribute more than the lower of either your or your spouse's earned income. If you are married, your spouse must be gainfully employed, actively seeking employment, a full time student, or disabled in order for you to participate in a Dependent Care Reimbursement Account.

Eligible Dependent Care Expenses

Dependent Care expenses must be for services that are required to allow you and your spouse to be gainfully employed. These include:

- Care for your dependent children under age 13 by a care center, nursery school, or baby-sitter. The caregiver may

be a relative, but not another dependent;

- Care for an elderly dependent, your spouse or any other legal dependent who is physically or mentally incapable of self-care, and who spends at least (8) hours a day in your home;
- Kindergarten;
- Registration fees for care. However, if the fee is paid to reserve a space at a later date, the reimbursement cannot be made until the service is actually rendered;
- Day camp. Does not include overnight camp.

Ineligible Dependent Care Expenses

- Dues or membership;
- Educational fees;
- Entertainment fees; (tickets, movies, skating, etc.)
- Fees for meals;
- Transportation fees;
- Fees for materials;
- Extra fees charged for late payments;
- Fees paid for children over 13 years of age.

Expenses must be for the care of eligible dependents and do not include educational costs, meals and incidentals. Internal Revenue Code regulations define educational expenses as those for grades 1-12.

The participant must provide a receipt, which includes the dependents name and age, caregiver's address, dates of service, amount charged, and a federal tax ID or Social Security Number. You must attach this receipt to the completed reimbursement claim form. Caregivers or care centers that are non-profit do not have to provide a federal ID or Social Security Number. However, this must be stated on the claim form.

IMPORTANT CONSIDERATIONS

Transferring Funds

You may not transfer money between the Medical and Dependent Care Reimbursement Accounts. Each account is a separate account and must be used only for the appropriate expense incurred. For example, if you submit a claim for dependent care expenses of \$200, but the current balance in your Dependent Care Account is only \$150, the additional \$50 cannot be paid from your Medical Reimbursement Account.

“Use It or Lose It” Rule

Because of the tax savings involved, the federal government has placed restrictions on reimbursement accounts. One restriction, referred to as “Use It or Lose It”, requires that any money remaining in your account(s) after you have submitted all your claims for the Plan Year will be forfeited. You may submit claims until the following April 15, but any funds for the Plan Year remaining after these claims are processed will be forfeited. Balances remaining from one Plan Year cannot be rolled over into the next Plan Year.

Forfeitures are used to defray the expenses of administering the plan when the employer must pay more than it has collected in premiums. In accordance with Section 110.161, Florida Statutes, all money forfeited from reimbursement accounts at the end of the Plan Year is transferred to the State of Florida Employees’ Group Health Trust Fund.

Making Your Election(s)

The “Use It or Lose It” rule makes planning and budgeting important. If you over-estimate your expenses and contribute too much money to your reimbursement account(s), you lose the excess at the end of the year. **Do not over-estimate your expenses; be conservative in the amount you elect to deposit into your reimbursement account(s)!**

Important questions to consider:

1. Does my estimate of care expenses take summer breaks into consideration?
2. Does the estimate consider changes in the type of care being provided, e.g. before and after-school care expenses, changing to K-Care, K-Care expenses ending-First grade starting?
3. Will any of your dependent(s) reach the age of 13 and no longer be eligible for dependent care reimbursement?

HOW TO FILE A CLAIM

Claim forms are available from your Agency Personnel Office, the Division of State Group Insurance, DSGI's Web site (<http://www.dsgi.state.fl.us>) or Fax-on-Demand (1-888-529-1747). After you incur an eligible expense, submit the completed claim form with proper documentation of the expense to the Division of State Group Insurance at the address on the form. Expenses will be reimbursed following the receipt of claims totaling \$25 or more, usually within four to six weeks. This \$25 minimum will be waived quarterly and at the end of the Plan Year.

Example: Joe Smith has three (3) prescriptions filled, and his co-payment is \$7.00. He files a reimbursement claim for his co-payments of \$21.00. DSGI will not release a check until Joe files claims for at least \$4.00 more in eligible expenses so the total claims are \$25.00 or more.

Reimbursement Account Claim Form Instructions and Information

A single claim form may be used for reimbursement from both types of accounts. The proper documentation must be attached to the claim form when it is submitted to DSGI to be considered for processing.

NOTE:
Your claims will be processed more quickly if you submit Medical and Dependent Care claims on separate claim forms.

Instructions are printed on the back of each claim form.

You may mail or deliver the claim form in person. Properly submitted claim forms will be processed within four to six weeks from receipt by the Division. Failure to comply with the filing instructions will delay the receipt of your reimbursement check. A sample claim form is shown on pages 24 and 25 with instructions.

Deadline For Filing Claims

You can submit claims throughout the Plan Year and up to April 15 of the following year. In other words, if you incur an eligible expense during the Plan Year (January 1 through December 31), you have until April 15 of the following year to deliver that claim to the Division of State Group Insurance. Remember, services must have been rendered during the Plan Year and during the time you were a Plan participant.

Special Note:

Do not wait to file your claims.

File them as soon as you have the proper documentation.

During certain times of the year, filings are heavier.

Waiting causes delays in processing your reimbursement.

CHANGES IN PLAN PARTICIPATION

Generally, elections you make under the Flexible Spending Accounts Program cannot be changed or cancelled during the Plan Year. Once a year an Open Enrollment will be conducted to allow employees to make benefit elections for the next plan year. Changes,

such as increasing or decreasing contributions or canceling participation, may be made at this time. **If changes are not submitted during the Open Enrollment period, coverage and amounts will remain the same for the next plan year.**

QUALIFYING STATUS CHANGES

A participant can change benefits only during Open Enrollment unless the participant experiences a specific Qualifying Status Change (QSC). Requests must be made by submitting a completed Enrollment/Qualifying Status Change Form and a FB-2 (for Reimbursement Accounts) to DSGI within 31 days of the event's occurrence. Documentation supporting the qualifying status change event will be required. Qualifying Status Changes generally must be made within 31 days of the event. The matrix beginning on page 13 indicates what changes are allowed for certain QSC events as of March 1, 2001.

Qualifying Status Changes must be made within 31 days of the event and include:

1. Changes in family or employment status, such as

- Marriage or divorce of the participant;
- Death of a spouse or dependent;
- Birth or adoption or legal guardianship of a dependent (must be made within 60 days of the event);

- Change from part-time to full-time employment or vice versa for a participant or spouse;
- Change in health coverage attributable to the spouse's employment;
- Spouse's employment or termination of employment;
- Unpaid leave of absence of at least 31 days for employee or spouse;

Consistent with the Event - Changes in election will be considered in these instances, provided that the requested change is consistent with the nature of the event. For example, the birth of a child would allow a participant to

HOW FLEXIBLE SPENDING PARTICIPATION MAY AFFECT OTHER BENEFITS

When you participate in the Pretax Premium component and/or the Reimbursement Account component of the Flexible Spending Accounts Program, you save both federal income and social security taxes. However, participation may affect the benefits you receive from other tax-deferred or employee benefit plans:

- **Social Security** - Over the long run, paying less Social Security taxes could slightly reduce your Social Security retirement or disability benefits. However, the taxes you save over the years should more than offset the slight reduction you might see at retirement.
- **Florida Retirement System (FRS)** - Your benefits from the FRS are not affected in any way by your participation in the Flexible Spending Accounts Program. FRS benefits are calculated on your gross salary before pretax premiums or reimbursement account contributions are deducted.
- **Life Insurance and Pay Raise Calculations** - Your pay raises and the value of your State Group Life Insurance will continue to be based on your base annual earnings, before pretax premiums or reimbursement account contributions are deducted. FSA participation will have no impact.
- **State University System Optional Retirement Program** - If you participate in the State University System Optional Retirement Program (ORP), the amount contributed by the State to your ORP account will not be affected by your participation in either part of the Flexible Spending Accounts Program. However, the maximum that you may contribute to the ORP will be based on your adjusted gross income, after pretax premium and/or reimbursement account contributions. Please contact the Division of Retirement for further information.
- **State Deferred Compensation Plan** - The State Deferred Compensation Plan allows you to tax-defer 25% or a maximum of \$10,000 per year of your income (after FSA deductions are taken), whichever is less. If you contribute the maximum or near the maximum, allowed under the State Deferred Compensation Plan, you should be aware that the Flexible Spending Accounts Program may affect your maximum allowed deferral. The examples and worksheet beginning on page 26 will help you determine if you might be affected. Contact the State of Florida Deferred Compensation Office or your deferred compensation provider if you have any questions.

FLEXIBLE SPENDING ACCOUNTS PROGRAM

PRETAX PREMIUM WORKSHEET

To estimate the amount of tax savings you will gain utilizing the pretax premiums component and the Flexible Spending Accounts Program, use the steps listed below.

Pretax Premiums

Requirements for Pretax Premiums:

Participants must pay a portion of their State Group Health Insurance premiums.

1. Participant's taxable income: _____
 - (a) Percentage from the table below
that corresponds to taxable income: _____
2. Annual State health, life, supplemental insurance and
Flexible Spending Accounts premiums: _____
3. Multiply line **2** by the tax rate **1a**.
Total tax savings with Pretax Premiums: _____

1999 Tax Rate Schedule

Total Taxable Income	Estimated Federal/FICA Tax Rate	
	Single	Married Filing Jointly
\$ 0 - 25,749	22.65%	22.65%
25,750 - 43,449	35.65%	22.65%
43,450 - 62,449	35.65%	35.65%
62,450 - 104,049	38.65%	35.65%
104,050 - 130,249	38.65%	38.65%
130,250 - 158,449	43.65%	38.65%
158,450 - 283,149	43.65%	43.65%
283,150 - and over	47.25%	47.25%

FLEXIBLE SPENDING ACCOUNTS PROGRAM

MEDICAL REIMBURSEMENT ACCOUNT WORKSHEET

A Medical Reimbursement Account enables you to pay for eligible health care expenses, not paid for by a health insurance program, with before-tax dollars.

Below are some eligible expenses which will help you determine the amount to elect for a Medical Reim-

bursement Account. Be conservative and estimate only the cost of the claims you are certain you will incur during the Plan Year, since unused money in your account will be forfeited. Expenses must be for services rendered during the Plan Year, January 1 through December 31, in which you are a plan participant.

Annual Expenses Not Paid by Insurance:	Last Year Actual	This Year Anticipated
Health coverage deductibles and co-payments	\$ _____	\$ _____
Dental coverage deductibles and co-payments	\$ _____	\$ _____
HMO co-payments	\$ _____	\$ _____
Dental/orthodontia expenses (non-cosmetic)	\$ _____	\$ _____
Well baby care (exams, newborn care)	\$ _____	\$ _____
Vision (glasses, contacts and supplies, exams)	\$ _____	\$ _____
Hearing (exams, hearing aids)	\$ _____	\$ _____
Surgery (non-cosmetic)	\$ _____	\$ _____
Physical exams (routine checkups)	\$ _____	\$ _____
Chiropractic and acupuncture	\$ _____	\$ _____
Eligible prescribed drugs	\$ _____	\$ _____
Psychiatric therapy & counseling	\$ _____	\$ _____
Total Cost	\$ _____	\$ _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT WORKSHEET 1

Eligible Dependents:

- Dependent children under age 13.
- Disabled spouse who requires care to allow you to work.
- Disabled dependent(s) incapable of self-care.

Note: Disabled or elderly dependents must regularly spend at least eight hours a day in the participant's home.

- Services must be for physical care, not education, meals, transportation etc.
- You must provide the name, address, taxpayer identification number or social security number of caregiver, dates of service, dependent's name and age, and the amount charged.

Limits:

Minimum Annual Contribution—\$60.00

Requirements for Eligibility:

- Care must be necessary to enable participant (and spouse, if married) to be gainfully employed or to attend school full-time.
- The annual contribution must NOT be greater than spouse's income or the participant's income, whichever is less.
- Services may not be provided by the participant's minor child or dependent.

Filing Status on Tax Return	Calendar Year Maximum
Married Filing Separately	\$ 2,500
Married Filing Jointly	\$ 5,000
Single	\$ 5,000

No more than \$5,000 can be contributed into your Dependent Care Account during any calendar year.

Consider changes in the types of care that will be provided throughout the upcoming Plan Year.

Estimated Expenses:	Last Year Actual	This Year Anticipated
Dependent Care/Before and After School Care	\$ _____	\$ _____
Nursery School	\$ _____	\$ _____
Other Eligible Care	\$ _____	_____
Total Cost	\$ _____	\$ _____

FLEXIBLE SPENDING ACCOUNTS PROGRAM

DEPENDENT CARE REIMBURSEMENT ACCOUNT WORKSHEET 2

Use this worksheet to estimate savings. Then decide which option, the federal tax credit or the Dependent Care Reimbursement Account, is more advantageous for you.

Estimated Dependent Care Tax Credit

Estimated Eligible Dependent Care (See limits on page 23) 1. \$ _____

Your Earned Income: 2. \$ _____

Spouse's Earned Income: (if applicable) 3. \$ _____

List on Line 4 the lower of Line 2 or Line 3. 4. \$ _____

List on Line 5 the lower of Line 1 or Line 4. 5. \$ _____

Add Lines 2 and 3. Based on this total income, select tax credit percentage from the table below. Enter this percentage on Line 6. 6. \$ _____

Dependent Care Income	Tax Credit Table Tax Credit %
\$ 0 - 10,000	30% (.30)
10,001 - 12,000	29% (.29)
12,001 - 14,000	28% (.28)
14,001 - 16,000	27% (.27)
16,001 - 18,000	26% (.26)
18,001 - 20,000	25% (.25)
20,001 - 22,000	24% (.24)
22,001 - 24,000	23% (.23)
24,001 - 26,000	22% (.22)
26,001 - 28,000	21% (.21)
28,001 and up	20% (.20)

Multiply the amount on Line 5 by the percentage on Line 6 and write in Line 7.

This is your estimated maximum dependent care tax credit. 7. \$ _____

FLEXIBLE SPENDING ACCOUNTS PROGRAM

Savings Utilizing Dependent Care Reimbursement Account

Estimated cost of dependent care: (See limits on Page 23) 8. \$ _____

Based on total earned income, (Line 2 plus Line 3),
select appropriate tax bracket from table below. Enter % here: 9. \$ _____

1999 Tax Rate Schedule

Total Earned Income		Estimated Federal/FICA Taxes	
		Single	Married Filing Jointly
\$ 0	- 25,749	22.65% (.2265)	22.65% (.2265)
25,750	- 43,449	35.65% (.3565)	22.65% (.2265)
43,450	- 62,449	35.65% (.3565)	35.65% (.3565)
62,450	- 104,049	38.65% (.3865)	35.65% (.3565)
104,050	- 130,249	38.65% (.3865)	38.65% (.3865)
130,250	- 158,449	43.65% (.4365)	38.65% (.3865)
158,450	- 283,149	43.65% (.4365)	43.65% (.4365)
283,150	- and over	47.25% (.4725)	47.25% (.4725)

Multiply Lines 8 and 9 and write in Line 10. This is your estimated savings using a Dependent Care Reimbursement Account 10. \$ _____

Which is better? Compare your estimated savings on Line 7 (the tax credit) with line 10 (the reimbursement account). Consult your tax advisor or the Internal Revenue Service if you need further clarification.

FLEXIBLE SPENDING ACCOUNTS PROGRAM

DEFERRED COMPENSATION WORKSHEET

The following example shows how a deferred compensation contribution could be affected by participation in pretax premiums and/or reimbursement accounts.

In this example, the participant could contribute a maximum of \$7,401.50 (\$29,606 X 25%) to his Deferred Compensation Plan. If he were contributing his maximum of 25% before participating in the pretax

premium plan, his deferral amount would have been \$7,750 (\$31,000 X 25%). He would need to contact his deferred compensation provider to make an adjustment. If your current annual deferred compensation contribution is more than the amount shown on your maximum deferral line, you will need to contact your deferred compensation provider to make an adjustment in your deferral.

Example:

Annual Salary	\$	31,000
Annual Pretax Health Insurance Premium	\$	1,394
Reimbursement Account Contribution	\$	- 0
Annual Pretax Supplemental Insurance Premium	\$	- 0
Adjusted Gross Income	\$	29,606
Maximum Deferred Compensation Contribution		x .25
	\$	7,401.50
		(or \$8,000 whichever is less)

Your Deferred Compensation Worksheet:

Annual Salary	\$	_____
Annual Pretax Health & Life Insurance Premium	- \$	_____
Annual Reimbursement Account Contribution	- \$	_____
Annual Pretax Supplemental Insurance Premium	- \$	_____
Adjusted Gross Income	\$	_____
Maximum Percent Contribution		x .25
Maximum Deferral	\$	_____
		(or \$8,000 whichever is less)

FLEXIBLE SPENDING ACCOUNTS PROGRAM



DIVISION OF STATE GROUP INSURANCE FLEXIBLE SPENDING ACCOUNTS - ENROLLMENT FORM PLAN YEAR _____



Select Your Type of Enrollment: ☐ **New Hire** ☐ **Qualifying Status Change** ☐ **Open Enrollment**
* NOTE: If checked, Agency Personnel Office must complete QSC Section in Part 3.
 PLEASE PRINT

Social Security Number: _____ - _____ - _____ Name: _____

Address: _____

Work Phone: () _____ SUNCOM: _____ Home Phone: () _____

Date of Birth: ____/____/____ Sex: _____ Payroll Mode: ☐ Monthly ☐ Biweekly

PART 1: ELECTION AMOUNTS

Medical Reimbursement

☐ I choose to participate in the Medical Reimbursement Account and elect:
 \$ _____ * annual amount
 for the remainder of the Plan Year

Dependent Care Reimbursement

☐ I choose to participate in the Dependent Care Reimbursement Account and elect:
 \$ _____ ** annual amount
 for the remainder of the Plan Year

The Plan Year is January 1 through December 31, and the amount(s) you elect is for this Plan Year OR THE REMAINING PORTION OF THE YEAR. The effective date of your enrollment is the date this properly completed form is received by the Personnel Office or the Division of State Group Insurance. Only claims for expenses incurred on or after the effective date could be eligible for reimbursement. Deductions are based on the number of payroll cycles remaining in the Plan Year.

PART 2: CHANGE IN FAMILY OR EMPLOYMENT STATUS (Documentation must be enclosed)

I have, or will experience a change in family or employment status on (date) _____
 My change is (Describe the event) _____
 Therefore, I wish to:

Medical Reimbursement

- ☐ Increase to \$ _____ annually.
☐ Decrease to \$ _____ annually.
☐ ENROLL with \$ _____

for the remainder of the Plan year*

Terminations may be executed on Medical Reimbursement Account - Termination of Employment FB-4 Form.

Dependent Care Reimbursement

- ☐ Increase to \$ _____ annually.
☐ Decrease to \$ _____ annually.
☐ ENROLL with \$ _____

for the remainder of the Plan year**

☐ Terminate Participation

The Division of State Group Insurance will determine if your request is consistent with federal provisions. If you are changing from a prior election, the new amount you elect should be the total dollar amount of ALL contributions you want deducted for the entire Plan Year.

* Limits for the Medical Reimbursement Account are: Maximum \$2,400; Minimum \$60.

**Limits for the Dependent Care Account are: Maximum \$5,000 if single or married filing jointly, OR \$2,500 if married filing separately; Minimum \$60.

Employees who have FSAs and do not want to change their annual elections do not have to do anything during Open Enrollment. Current annual deductions will be continued in the next plan year.

I authorize the amount(s) elected to be deducted from my salary or wages on a pretax basis. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year in accordance with the Internal Revenue Code Section 125 if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for the expenses are not filed with the Division of State Group Insurance by the claims filing deadline date following the Plan Year (April 15). I further understand that the above elections can NOT be revoked or changed during the Plan Year unless I experience a qualifying change in family or employment status as defined by the IRC and Rule 60P, F.A.C..

Employee Signature: _____ Date: _____

PART 3: AGENCY CERTIFICATION REQUIRED

Hire Date: ____/____/____ SAMAS Org Code: _____

Coverage Effective Date: ____/____/____ Employment Status: _____ Work Phone: () _____

Agency Signature: _____ Date: ____/____/____ SUNCOM: _____

* QSC Code: _____ *QSC Date: ____/____/____ ☐ Check if the employee is an 8, 9 or 10 month faculty member.

FLEXIBLE SPENDING ACCOUNTS PROGRAM

INSTRUCTIONS

Prior to the completion of this form, please read the current Annual Open Enrollment Benefits booklet. The publication will help you estimate eligible expenses and help determine if you will benefit from plan participation. Copies are available from your personnel office or the Division of State Group Insurance (DSGI) - (850) 921-4525 or Suncom 291-4525.

Return this completed form to your personnel office. It must be received within 60 days of your employment or within 31 days of a change in family / employment status. **The effective date of plan participation or change in participation will be based on the date the properly completed form and documentation are received by your personnel office or DSGI.**

Employee Information

Complete all the personal information that is requested, including your payroll mode.

Part 1: Election Amount(s)

Check the appropriate boxes and designate the amount(s) you wish to contribute to your Medical and/or Dependent Care Reimbursement Account(s) for the current Plan Year. The Plan Year ends December 31. The annual minimum contribution is \$60 for both the accounts and the maximum contribution is \$2,400 for the Medical Reimbursement Account. The maximum is \$5,000 for the Dependent Care Account if you are single, or married and filing jointly on your income tax, or \$2,500 if you are married filing separately on your income tax.

Contributions from your paycheck will be based on the remaining number of pay periods in the Plan Year when your Enrollment/Qualifying Status Change Form is received by DSGI.

Part 2: Change in Family or Employment Status

A participant may be allowed to change the annual election amount(s) when a change in family or employment status is experienced, subject to provisions of the Plan. Changes in family or employment status include marriage or divorce of a participant, death of a spouse or dependent, birth, adoption or obtaining legal guardianship of a child, change from part-time to full-time employment or vice versa for a participant or spouse, spouse attaining or terminating employment, unpaid leave over 31 days for participant or spouse and change in dependent eligibility.

Indicate when the change occurred or will occur and the type of change. Attach documentation of the event, i.e. (certificates, licenses, decrees). DSGI will not process your request until the proper documentation is received. Depending on the nature of your change in status, you may be able to enroll, increase, and/or decrease participation. The requested change must be consistent with the event for the enrollment or change to be approved.

Part 3: Agency Certification

To be processed, this form must be signed and dated by the employee/participant and agency. Your personnel office will complete this section and forward to:

Division of State Group Insurance
P.O. Box 6357
Tallahassee, Florida 32314-6357



For questions on completing the form, status of enrollment, how the plan works or claims inquiries call (850) 921-4604, Suncom 291-4604

TOPICS & TIPS FOR REIMBURSEMENT ACCOUNT PARTICIPANTS

The State of Florida is pleased to offer its employees tax-saving benefit options through the Flexible Spending Accounts Program - Reimbursement Accounts. The Medical and Dependent Care Reimbursement Account options provide the employee with the opportunity to pay for out-of-pocket expenses using pretaxed funds. The annual election amounts that participants choose during the enrollment period are deducted from their gross salaries prior to taxes being computed, thus reducing their taxable incomes and increasing their spendable incomes.

Claim Form Completion

The Reimbursement Account Claim Form (FB-3) provides enough space for the participant to file up to 10 medical expense items and up to 4 dependent care expense items. The form has 4 parts:

- Part 1- Participant Information Section
- Part 2 - Medical Expense Filing Area
- Part 3 - Dependent Care Expense Filing Area
- Part 4 - Participant Certification Section

Parts 1 and 4 must be completed by all claim filers, and Parts 2 and 3 (as applicable) must be completed with the patient's or dependent's name, the date(s) of service, the provider's name and address, type(s) of service, and the amount the participant wishes to claim for reimbursement.

Documentation Requirements

The Plan, as required under Internal Revenue Code, Section 125, must require specific receipt documentation for all expenses that will be reimbursed.

For medical expenses which are covered by any type of insurance, a statement from the insurance provider

indicating the patient's financial responsibility for a service, is required. For expenses not covered by any type of insurance, a third party receipt (or bill) indicating patient's name, provider's name and address, type and date of service and the expense, is required as documentation.

For dependent care expenses, the receipt documentation must include the following elements: (1) the provider's name, (2) address, (3) tax I.D. or Social Security Number, (4) the dependent's name, (5) the dependent's age, (6) date(s) of service (7) and the expense.

To prevent documentation from being lost, receipt documentation for each claim should be organized and taped to an 8 1/2 x 11 sheet of paper and attached to the claim form. When the required elements are included on the receipt documentation, organized and enclosed with the claim form, processing can proceed smoothly if the expense is otherwise eligible.

Claims Filing Deadline Date

Each Plan Year (Jan. 1 thru Dec. 31) has a designated claims filing deadline date of April 15 of the following year. This means that all claims for expenses incurred during an employee's participation must be postmarked by midnight April 15 of the following year to be considered for processing. Any claims received after this date will be returned to the participant unprocessed regardless of account balances. We encourage participants to file claims as soon as the service is rendered and the required documentation is obtained.

The Internal Revenue Code provisions governing the Plan indicate that if there are unused balances in a participant's account for which no expenses are incurred, the funds are forfeited. This "use it or lose it" rule must be enforced by the Plan to continue as a tax-free benefit option. Also, for a participant that has both

FLEXIBLE SPENDING ACCOUNTS PROGRAM

accounts, if there are excess expenses for one account that has no balance, the Plan cannot allow a “shift” of funds from the other account so the participant can use it. Each account is separate from the other.

Eligible and Ineligible Expenses

The following are examples of the most common expenses filed for reimbursement:

Medical Reimbursement Account (MRA)

To be eligible, these expenses must be medically necessary and prescribed by your physician.

Eligible expenses - Office visit co-payments; dental visit payments or co-payments; vision care, glasses, contact lenses; insurance plan deductibles; hearing aids and batteries; orthodontia; prescription drugs (non-cosmetic).

Ineligible Expenses - Weight loss related expenses; expenses which are cosmetic in nature: teeth bleaching/veneering, Rogaine/Retin-A; over-the-counter medications/supplies; club (fitness) or organizational dues; warranty fees (eye glasses).

Common Documentation Problems

To protect the tax-free status of participant funds, the Plan is specific about required documentation. The following are examples of often filed documentation that **CANNOT** be used to validate the eligibility of claims for reimbursement:

- Care receipts that do not contain all 6 elements of information and an original provider signature;
- Medical receipts that reflect “Paid on Account”;
- Medical statements indicating “estimated patient responsibility”;
- Cash register or credit card receipts;
- Copies of canceled checks;
- Photocopies that are not legible or have essential information cut off.

Dependent Care Reimbursement Account (DC)

To be reimbursable, the expenses must be for dependent care services which are required to allow both you and your spouse to be gainfully employed. Participation amounts are dependent upon the lesser of the two household incomes.

Eligible Expenses - Care; kindergarten; registration fees; summer camp (non-tutorial, no overnight); before and after school care (non-tutorial); under the age of 13; elderly dependents.

Ineligible Expenses - Dues or memberships; supplies, meals, insurance or transportation fees; late payment charges.

The listings above are not complete listings. As a general rule, the medical expenses a person is allowed to file on IRS Form 1040 Schedule A (see **IRS Publication 502**) are eligible for reimbursement under this Plan. For dependent care expenses, the same general rule applies to the filing of IRS Form 2441 (See **IRS Publication 503**).

For further information on participation or accounts, please contact DSGI at (850) 921-4604 or SUNCOM 291-4604.

FLEXIBLE SPENDING ACCOUNTS PROGRAM



DIVISION OF STATE GROUP INSURANCE FLEXIBLE SPENDING ACCOUNTS PROGRAM REIMBURSEMENT CLAIM FORM

FOR INTERNAL USE ONLY	
PROCESSOR:	
DATE:	PAGE:

PART 1 PARTICIPANT INFORMATION (Please Print) *See back for general information.*

Social Security Number	For Plan Year	Home Phone #		
		Office Phone #		SUNCOM #
Last Name	First Name	M.I.	Department/Agency	
Address	City	State	Zip	<input type="checkbox"/> Check here if change of address.

PART 2 UNREIMBURSED MEDICAL EXPENSES *See back for documentation information.*

	PATIENT'S NAME	DATES OF SERVICE FROM - TO	SERVICE PROVIDER / TYPE OF SERVICE	EXPENSE INCURRED	FOR INTERNAL USE ONLY	
					CODE	AMOUNT
A						
B						
C						
D						
E						
2A						
2B						
2C						
2D						
2E						

PART 3 DEPENDENT CARE EXPENSES (See back for documentation information.)

Care for: children under age 13- nursery school, day care center, baby-sitter or an elderly dependent, spouse or other legal dependent who is incapable of self-care and who spends at least 8 hrs/day in your home.

	DEPENDENT'S NAME	AGE	DATES OF SERVICE FROM - TO	SERVICE PROVIDER / TYPE OF SERVICE	EXPENSE INCURRED	FOR INTERNAL USE ONLY	
						CODE	AMOUNT
F							
G							
H							
I							

PART 4 PARTICIPANT'S CERTIFICATION OF REQUEST

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Care Expenses which I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expenses for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Care Expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Participant's Signature: _____ Date: _____

FLEXIBLE SPENDING ACCOUNTS PROGRAM

Following each Plan Year (January 1 through December 31),
April 15 is the final deadline for filing all claims.

General Information

- You may use one form to file claims for Medical Expense and Dependent Care reimbursement accounts.
- You may file up to ten Medical and four Dependent Care expenses on one form. *Note: Attach additional forms if more space is needed.*
- You may use copies of this claim form if no originals are available.
- **You must file claims for different years on separate forms.**
- Expenses must be for dates of service rendered during the Plan Year (calendar year). *Note: Your eligible participation period may be different depending on your enrollment date, or if you terminate participation during the year.*
- Your claim form must have receipt documentation attached to it **before** it can be processed.
- Eligible expenses are based on when the services were rendered, **not** when billing or payment for services occurs.
- To **change your address**, the W-4 form in your personnel office must be changed.
- If you are reimbursed for any expense that is later paid by insurance or refunded by any means, you must report this to the address below. Your account will be adjusted.
- Cancelled checks, cash register receipts, or credit card receipts are **not** acceptable as receipt documentation.

Medical Expense Documentation

Expenses for dates of service after you terminate employment are not eligible for reimbursement unless advance arrangements have been made to continue contributions to your Medical Account.

MEDICAL SERVICES

- For services covered by insurance, you must attach statements from the insurance company indicating patient responsibility for the expense.
- For services not covered by insurance you must attach itemized receipts or bills that include: patient's name, date of service, type of service, provider's name and address, and the expense.

PRESCRIPTION DRUGS

- Your receipts must include patient's name, date of service, pharmacy name and address, and the expense.
Note: The pharmacy prescription label generally contains the necessary elements for required documentation.
- Non-prescribed or over-the-counter items are not reimbursable.

Dependent Care Documentation

- Your receipt must include: the provider's name, address, tax identification number or Social Security number, a description and date(s) of service(s); the dependent's name, dependent's age, and an itemized statement of the expense.
- To qualify for reimbursement your child must be age 12 and under.
- To qualify for reimbursement your child or other dependent over the age of 13 must be incapable of self support and spend 8 hours or more a day in your home.
- If you make advance payments or pre-pay any fees, submit your claim for reimbursement after the service has begun.

Mail or Deliver Claims to

Division of State Group Insurance
Reimbursement Account Claims
Post Office Box 6357, 4040 Esplanade Way
Tallahassee, Florida 32314-6357

DSGI
WE'VE GOT YOU COVERED

For more information, contact DSGI at (850)921-4610 or SUNCOM 291-4610.

FB-3-9-01
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MEDICAL REIMBURSEMENT ACCOUNT TERMINATION OF EMPLOYMENT (FB-4) PERSONNEL OFFICE PROCEDURES

When an employee who participates in a Medical Reimbursement Account gives notice of termination, the Personnel Office should immediately complete and process the Medical Reimbursement Account Termination Form (FB-4). This will allow the employee a full range of payment options if he elects to continue participation.

Remember, if the participant wishes to be eligible to file claims for expenses incurred after the coverage period that corresponds with the payment from his final regular salary warrant, he must continue participation by making payment to his account, regardless of account balance at termination.

The Personnel Office should work with the employee to complete the form as follows:

Section I - Participant Information

The terminating employee should complete this section with the assistance of the Personnel Office. The Personnel Office should provide the correct SAMAS Account Code and ensure that the termination date reflects the actual (or scheduled actual) last day of work. It should also be noted whether the agency is on bi-weekly or monthly payroll cycle. The payroll ending date will determine whether contributions can be deducted from annual and/or sick leave payments.

Section II- Current Account Status

The Personnel Office must contact the FSA Section at (850) 921-4604, SUNCOM 291-4604 to ensure that the information necessary to complete this section is accurate. Information included is:

Current Account Balance - This reflects Current Plan Year-to-Date Contributions less any claims paid as of the date listed. A negative amount means that claims payment has exceeded contributions.

Annual Election - Total amount of annual benefit selected by the participant for the Plan Year.

Current Plan Year-to-Date Contributions - Total deposits made to the Medical Reimbursement Account by payroll deduction as reflected on the COPES screen and FSA Section records.

Additional Regular Payroll Contributions Due Before Termination - Depending on the participant's termination date and payroll cycle, an additional deposit may be made to the account after termination in the final regular salary warrant. This may not be reflected in the Current Plan YTD Contributions above, and an adjustment must be made to accurately calculate the remaining Balance Due to Meet Annual Election.

Total Plan Year-to-Date Contributions at Termination - This is total contributions that will be made by payroll deduction through the participant's final regular salary warrant, not including the annual or sick leave payment.

Balance Due to Meet Annual Election - This is the difference between the participant's Annual Election and Total Plan Year-to-Date Contributions at Termination. This is the amount that the participant must contribute to Plan Participation until the end of the current Plan Year. He is given a choice of payment options.

Section III- Participation/Payment Options

The Personnel Office should get the amounts and dates for each of the various payment options from the FSA Section by calling (850) 921-4604, SUNCOM 291-4604.

The employee must indicate if he elects to continue participation or not by marking the appropriate box. If he elects to continue participation, he must select a payment option. If payment option (d) is selected, the employee must initial next to the payment amount he selects and make payment by the due date. If payments are not made when due, termination of participation due to non-payment of premiums will result.

The employee must sign and date the form.

If the employee has questions, he may contact the FSA Section.

Form Distribution and Processing

Copy 1 - Send to:

DSGI Flexible Claims Reimbursement Section
P.O. Box 6357
Tallahassee, Florida 32314-6357

Copy 2 - Make a Copy for Comptroller's Office

If employee elects Full or Partial Payment from his annual or sick leave payment of the balance due to meet his annual election (option A or B), send with applicable payroll documents to:

Comptroller's Office
Bureau of State Payrolls
Room B23, The Fletcher Building
Tallahassee, Florida 32399-0350

Form and payroll documents must be received before the applicable cutoff. Warrant information should be submitted for manual processing and not automated processing. Please refer to the Bureau of State Payroll's Payroll Preparation Manual, Volume V, Section 4, for manual processing.

If employee elects option c or d, the Personnel Office retains copy.

Copy 3 - Make a Copy for Your Records

Employee Copy.

FLEXIBLE SPENDING ACCOUNTS PROGRAM



Division of State Group Insurance

FLEXIBLE SPENDING ACCOUNT PROGRAM

Medical Reimbursement Account - Termination of Employment Form



SECTION I PARTICIPANT INFORMATION (Please Print) (Instructions are on the back of this form)

Social Security Number - -	Last Name	First Name	M.I.	Paid: <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly
Address		City/State/Zip Code		
Home Phone #	Agency SAMAS:	TERMINATION DATE:		

SECTION II CURRENT STATUS OF ACCOUNT (To be completed by Personnel Office and DSGI)

Current Account Balance as of ___/___/___ : \$ _____

- | | |
|--|---|
| 1) Annual Elected Amount: | \$ _____ |
| 2) Current Year-To-Date Contributions (last deposit on ___/___/___): | \$ _____ |
| 3) Additional Regular Payroll Contributions If Any: | \$ _____ |
| 4) Total Plan Year-To-Date Contributions Upon Final Regular Payroll (add lines 2 & 3): | \$ _____ |
| 5) Balance Due to Meet Annual Elected Amount (subtract line 4 from line 1): | \$ |

SECTION III PARTICIPATION/PAYMENT OPTIONS

(For Assistance Contact the Flexible Spending Account section at (850) 921-4604 or SUNCOM 291-4604)

If the employee does not wish to continue participation, they must indicate it on this form by electing to terminate Plan Participation. To continue plan participation, the employee must indicate their choice in the appropriate section and specify the payment option. The payment agreement must be honored in order to continue participation. The employee must sign and date this form.

- ☐ I elect to continue participation for the balance of the Plan Year by making my Medical Reimbursement Account premium contributions by the method marked below. I understand that if I do not honor my payment agreement, my participation in the Plan will be terminated and I will not be eligible to file claims for expenses incurred after my period of participation and that I will not be eligible to resume participation if I am rehired by the State during the current Plan Year. I understand that it is my sole responsibility to make any payments by personal check or money order that are required by the due date, payable to the "Pretax Benefits Trust Fund" and that I will not receive any notice of payments due or of non-payment.
- ☐ a) Full Payment of Balance Due of \$ _____ (from line 5) made on a pretax basis from my annual or sick leave payment. If these funds are not sufficient to pay the Balance Due, I authorize payment of the full amount available, up to the amount listed in this option and will pay the difference by personal check or money order within 45 calendar days of my leave payment processing date.
- ☐ b) Partial payment of \$ _____ (\$ _____ minimum) made on a pretax basis from my annual or sick leave payment. The Remaining Balance of \$ _____ will be paid by personal check or money order within 45 days of the signature date on this form, or the processing of my leave payment, whichever occurs first. If leave funds are not sufficient to cover the designated partial payment, I authorize payment of the full amount available, up to the partial payment amount listed in this option. I will meet my Remaining Balance Payment by personal check or money order accordingly.
- ☐ c) Full payment of \$ _____ paid by personal check or money order within 45 calendar days of the signature date on this form.
- ☐ d) Monthly payments by personal check or money order due on the first day of each month as follows: (Check and initial beside the monthly plan you choose.)

Number of payments ____ of \$ _____ beginning ___/___/___	✓	Initials
Number of payments ____ of \$ _____ beginning ___/___/___	<input type="checkbox"/>	<input type="text"/>
Number of payments ____ of \$ _____ beginning ___/___/___	<input type="checkbox"/>	<input type="text"/>
Number of payments ____ of \$ _____ beginning ___/___/___	<input type="checkbox"/>	<input type="text"/>

Payments are due on the first day of each month and include a 2% administrative fee.

- ☐ I elect to terminate Plan Participation. I understand that any claims for expenses incurred after my period of participation will not be eligible for reimbursement and that if I am rehired by the State during the current Plan Year, I will not be eligible to resume participation.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

PERSONNEL OFFICER SIGNATURE: _____ DATE: _____

FLEXIBLE SPENDING ACCOUNTS PROGRAM

INSTRUCTIONS

SECTION I - PARTICIPANT INFORMATION

To be completed by the terminating employee with the assistance of the employee's Personnel Office. The correct SAMAS Account Code, payroll cycle (biweekly or monthly), and termination date should be provided by the Personnel Office.

SECTION II - CURRENT ACCOUNT STATUS

The Flexible Benefits Claims Reimbursement Section must be contacted to assist in the completion of this section. It gives information on which the employee's payment options in Section III are based.

SECTION III - PARTICIPATION/PAYMENT OPTIONS

The Flexible Benefits Claims Reimbursement Section must be contacted to provide the amounts and dates for the payment options. The employee must indicate if he/she elects to **continue participation** or **terminate participation**. If the employee elects to continue participation, a payment option must be selected. The employee must sign and date the form. The employee should contact the Reimbursement Section with any questions.

FORM DISTRIBUTION AND PROCESSING

Provide a copy of your completed form to the following:

1. Division of State Group Insurance
Claims Reimbursement Section
Post Office Box 5450
Tallahassee, Florida 32314-5450

2. Employees who elect Full or Partial Payment from annual or sick leave payment (option a or b), should attach applicable manual payroll documents to a copy of the form and send it to:

Comptroller's Office
Bureau of State Payrolls
Room B23, The Fletcher Building
Tallahassee, Florida 32399-0350

The form and payroll documents **MUST** be received before the applicable payroll cutoff. **NOTE:** The Personnel/ Finance Office should submit warrant information for **MANUAL PROCESSING**. Please refer to the Bureau of State Payrolls' Payroll Preparation Manual, Volume V, Section 4, for information on manual processing procedures. If the employee elects any other option, (option c or d): Personnel Office retains copy 2.

3. Keep a copy for your records.

FOR ASSISTANCE

Contact the Division of State Group Insurance, Claims Reimbursement Section at (850) 921-4604, SUNCOM 291-4604 for assistance in completing this form.

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