

# FSA Guide



**King County**

Benefits and Retirement  
Operations

Flexible Spending Accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA, you do not pay federal or FICA (Social Security) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

King County offers two types of FSAs:

- Health Care FSAs allow you to set aside pretax dollars to pay for certain expenses not covered by your health plans (for example, the cost of orthodontia not fully paid by your dental plan and copays for office visits).
- Dependent Care FSAs allow you to set aside pretax dollars to pay for eligible dependent care services on a regular basis for your child, disabled spouse or dependent parent while you and your spouse work.

This guide explains how FSAs work. If you want to enroll in an FSA, you must submit an FSA Enrollment form *within 30 days of when your other benefits begin*.

To keep your FSA participation current, you must re-enroll each year.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this guide and the contracts or other legal documents, the legal documents will always govern. King County intends to continue this plan indefinitely but reserves the right to amend or terminate them at any time, for any reason, according to the amendment procedures described in the legal documents. This guide does not create a contract of employment between King County and any employee.

**Call 206-684-1556 for alternate formats.**

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## Administrative Facts

The following is plan information you might need for your benefit claims and questions.

Plan Name	Health Care Flexible Spending Account Dependent Care Flexible Spending Account
Plan Year	January 1 – December 31
Plan Sponsor	If you have questions about FSA eligibility or enrollment, contact Benefits and Retirement Operations. The FSA plan booklet and FSA Guide are available at <a href="http://www.metrokc.gov/employees/benefits/flexible_spending_accounts/default.aspx">www.metrokc.gov/employees/benefits/flexible_spending_accounts/default.aspx</a> .  Benefits and Retirement Operations Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598 Phone 206-684-1556 ■ 1-800-325-6165 x41556 (outside local calling area) Fax 206-684-1925 E-mail <a href="mailto:kc.benefits@metrokc.gov">kc.benefits@metrokc.gov</a> Web <a href="http://www.metrokc.gov/employees/benefits">www.metrokc.gov/employees/benefits</a>
Plan Administrator	The FSA Plan is administered for King County according to the terms of an agreement with Fringe Benefits Management Company (FBMC). Contact FBMC if you have questions about eligible expenses or reimbursements.  Fringe Benefits Management Company (FBMC) P.O. Box 1878 Tallahassee, Florida 32302-1878 Phone 1-800-342-8017 Fax 1-850-425-4608 Web <a href="http://www.myFBMC.com">www.myFBMC.com</a>
Plan Funding	Plan benefits are funded through employee pretax salary-deduction contributions, as permitted by Internal Revenue Code Section 125.
Plan Expenses	In general, King County pays the administrative expenses of the Plan, to the extent those expenses are not paid from the Plan.

## How FSAs Work

You decide how much you want to contribute through payroll deduction to either a Health Care or a Dependent Care FSA (or both) and indicate the amount on the FSA Enrollment form. Benefits and Retirement Operations will verify your eligibility and transmit the information to Payroll (so deductions can be taken) and a third-party administrator, Fringe Benefits Management Company (FBMC). FBMC sets up your FSA and administers it for King County.

As you incur eligible expenses, you submit reimbursement claim forms (provided when you enroll and available from FBMC), receipts and other required documentation to FBMC, and FBMC reimburses you from your account. Reimbursement requests are processed within 5 days of receipt. If the reimbursement is approved, a check is issued or a direct deposit transmitted the night your request is processed, and an explanation of reimbursement is mailed to your home. (Direct deposit forms are available from FBMC.)

You may submit reimbursement requests for expenses incurred during the calendar year any time through March 31 of the following year (requests must be received by FBMC no later than March 31), and you may submit multiple bills or receipts with one reimbursement claim form as long as you list them on the claim form.

# Health Care FSAs

## ► FSA versus Federal Income Tax Deduction

The IRS allows you to take a federal income tax deduction for certain eligible health care expenses if they exceed 7.5 % of your adjusted gross income, or you may set aside from \$300 (minimum) to \$6,000 (maximum) in pretax dollars in a calendar year to pay for these same expenses from a Health Care FSA. For most people, the Health Care FSA makes the most sense, but consult a tax advisor to be sure.

## ► Dependent Eligibility

You may use a Health Care FSA to reimburse expenses for any family member who qualifies for coverage under your benefit plans. However, Internal Revenue Code Section 152 restricts use of a Health Care FSA to reimburse expenses for a domestic partner and domestic partner’s children unless they live with you as members of your household and you provide more than half their support during the FSA calendar year.

Internal Revenue Code Section 152 also allows you to reimburse expenses for:

- Any child, grandchild, stepchild, brother, sister, stepbrother, stepsister, parent, grandparent, stepparent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law who receives over half his/her support from you during the FSA calendar year
- Any person not related to you but who lives with you as a member of your household and receives more than half his/her support from you during the FSA calendar year.

If you reimburse expenses from a Health Care FSA for any dependents other than your spouse or dependent children, you may be required to provide an affidavit certifying them as eligible dependents based on the criteria described above.

## ► Eligible Expenses

Below is a partial list of health care expenses eligible for reimbursement through a Health Care FSA (more eligible expenses are listed on the FBMC website; see Resource Directory, page 12). Consult with your tax advisor, IRS Publication 502 or FBMC if you have any questions. The IRS publication references insurance premiums and long-term care insurance as eligible deductible expenses on an individual tax return, but they are not eligible for Health Care FSA reimbursement.

Eligible Expenses	
<ul style="list-style-type: none"> <li>● Acupuncture</li> <li>● Ambulance</li> <li>● Artificial limbs</li> <li>● Birth control pills, condoms, spermicides, pregnancy/ovulation kits</li> <li>● Braille books and magazines</li> <li>● Car controls for a disabled person</li> <li>● Care for a mentally disabled child</li> <li>● Chiropractor fees</li> <li>● Christian Science practitioner fees</li> <li>● Coinsurance/copays</li> <li>● Contact lenses and contact cleaning solutions</li> <li>● Cosmetic procedures to correct a problem arising from a medical condition</li> <li>● Crutches</li> <li>● Deductibles for medical, dental and vision plans</li> </ul>	<ul style="list-style-type: none"> <li>● New baby expenses for medical conditions</li> <li>● Obstetrical services</li> <li>● Over-the-counter-drugs used to treat/prevent illness/injury (limited)</li> <li>● Operations</li> <li>● Optometrist</li> <li>● Orthodontics (noncosmetic purposes)</li> <li>● Orthopedic shoes</li> <li>● Oxygen</li> <li>● Physician fees</li> <li>● Prescription drugs</li> <li>● Psychiatric care</li> <li>● Psychologist fees</li> <li>● Radial keratotomy</li> <li>● Routine physicals</li> <li>● Seeing-eye dog and its upkeep</li> </ul>

Eligible Expenses	
<ul style="list-style-type: none"> <li>● Dental fees</li> <li>● Dentures</li> <li>● Diagnostic fees</li> <li>● Disabled person's cost for special home</li> <li>● Drug addiction treatment</li> <li>● Eyeglasses</li> <li>● Eye exams</li> <li>● Fertility treatment</li> <li>● Hearing aids and batteries</li> <li>● Home improvements for medical reasons</li> <li>● Hospital bills</li> <li>● Hypnosis for treatment of an illness</li> <li>● Insulin</li> <li>● Laboratory fees</li> <li>● Learning disability</li> <li>● Life fee to retirement home for medical care</li> <li>● Maternity care</li> <li>● Naturopathic treatment</li> <li>● Naturopathic remedies (if prescribed by physician for medical condition)</li> </ul>	<ul style="list-style-type: none"> <li>● Skilled nurse fees (including board and Social Security taxes you pay)</li> <li>● Smoking cessation</li> <li>● Spa/pool equipment prescribed by physician and allowed by the IRS</li> <li>● Special schools for mentally impaired or physically disabled person</li> <li>● Telephone designed for hearing-impaired person</li> <li>● Television/hearing-impaired equipment</li> <li>● Therapeutic care for drug and alcohol addiction</li> <li>● Therapy received as medical treatment</li> <li>● Transportation expenses for medical purposes</li> <li>● Tuition at special school for a disabled person</li> <li>● Tuition fee portion that goes for medical care</li> <li>● Vaccines</li> <li>● Weight loss programs (if prescribed by physician for medical condition)</li> <li>● Well-baby and well-child care</li> <li>● Wheelchair</li> <li>● Wigs required for medical purposes</li> <li>● X-rays</li> </ul>

**► Ineligible Expenses**

Below is a partial list of health care expenses not eligible for reimbursement through a Health Care FSA. Again, consult with your tax advisor, IRS Publication 502 or FBMC if you have any questions.

Ineligible Expenses	
<ul style="list-style-type: none"> <li>● Cosmetic procedures for nonmedical reasons</li> <li>● Diaper services</li> <li>● Divorce expenses (even if recommended by a physician)</li> <li>● Domestic help fees (for services of a non-medical nature)</li> <li>● General counseling (family, marital or couple)</li> <li>● Health club programs, including fitness clubs and gyms</li> <li>● Health insurance premiums</li> </ul>	<ul style="list-style-type: none"> <li>● Lens replacement insurance</li> <li>● Long-term care insurance premiums and expenses</li> <li>● Maternity clothes</li> <li>● Parking fees</li> <li>● Physical therapy treatments for general well-being</li> <li>● Vitamins, supplements and remedies taken for general well-being</li> </ul>

**► Expense Estimator**

All eligible expenses for you, your spouse and your eligible dependents are reimbursable from your Health Care FSA. Complete the Expense Estimator Worksheet on the following page to estimate eligible health care expenses not covered by your other benefits.

Expense Estimator Worksheet			
Medical Expenses	Estimated Calendar Year Expenses	Vision Expenses	Estimated Calendar Year Expenses
Copays	\$ _____	Copays	\$ _____
Deductibles	\$ _____	Deductibles	\$ _____
Physical exams	\$ _____	Eye exams	\$ _____
Prescription drugs	\$ _____	Prescription contact lenses	\$ _____
Surgical fees	\$ _____	Contact lens supplies	\$ _____
X-ray or lab fees	\$ _____	Prescription eyeglasses or sunglasses	\$ _____
Other medical expenses	\$ _____		
Dental Expenses		Other Expenses	
Copays	\$ _____	Acupuncture, chiropractors, naturopaths	\$ _____
Deductibles	\$ _____	Hearing aids	\$ _____
Dentures	\$ _____	Immunization fees	\$ _____
Examinations	\$ _____	Psychiatrist, psychologist, counseling (allowed for treatment of specific physical or mental disorder (for example, depression, alcohol or drug treatment; diagnosis is necessary for reimbursement)	\$ _____
Orthodontia	\$ _____		
Restorative work (crowns, caps, bridges)	\$ _____		
Teeth cleaning	\$ _____		
Other dental expenses	\$ _____		
<b>Total Column 1</b>	\$ _____	<b>Total Column 2</b>	\$ _____

Total Column 1 \$ \_\_\_\_\_ + Total Column 2 \$ \_\_\_\_\_ = Total Estimated Expenses \$ \_\_\_\_\_

**► Expense Reimbursement**

How eligible expenses are reimbursed from a Health Care FSA depends on the type of expense you have: expense partially covered by health insurance, expense not covered by health insurance, or orthodontia expense.

For expenses partially covered by insurance, you file a claim with your health plan. When you receive your Explanation of Benefits (EOB), you see how much the plan paid and the remaining balance due. You then request reimbursement for the remaining balance.

Mail or fax a completed FSA Reimbursement Request Form available from FBMC (see Resource Directory on page 12) along with the following:

- An invoice from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided, and
- An Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost, or
- A written statement from your health care provider indicating that the service was medically necessary if the service could be deemed cosmetic in nature, accompanied by the invoice for the service.

For expenses not covered by insurance, complete the claim form and attach your itemized receipt for the expenses. Receipts must show date of service, cost, service performed and provider of service. Canceled checks, credit card receipts or statements showing only "balance due" or "payment on account" cannot be accepted. Fax or mail the information to FBMC.

A lump sum payment is eligible for full reimbursement for orthodontia services. To be reimbursed, you must provide documentation such as a receipt of payment, claim form or payment coupon, and it must include the patient name, provider name, date of service and cost of service. An orthodontia worksheet is no longer required, but a copy of your contract is required. Monthly payments will be reimbursed based on the actual amount paid. Orthodontia payments may be reimbursed over multiple plan years.

When your Health Care FSA reimbursement request is received and approved, you are reimbursed for eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year.

### ► **If Reimbursement is Denied**

If your request for a mid-year change to your FSA, an FSA reimbursement claim or other similar request is denied, in full or in part, you have the right to appeal the decision by sending a written request for review within 30 days of the denial to:

FBMC – Appeals Process  
P.O. Box 1878  
Tallahassee, FL 32302-1878

Your written appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- The denial letter you received
- Why you think your request should not have been denied, and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt of your appeal and supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 days. If your appeal is approved, additional processing time is required to modify your account.

Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer, insurance provider and IRS regulations governing the plan.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on.

## **Dependent Care FSAs**

### ► **FSA versus Federal Income Tax Deduction**

If you work full-time or part-time and have children, a disabled spouse or elderly dependent parents and use dependent care services (that is, child daycare, adult day care on a regular basis), you may take an

income tax credit for your dependent care expenses or you may set aside pretax dollars to pay for these same expenses from a Dependent Care FSA

The minimum you may contribute to a Dependent Care FSA is \$300 per calendar year. The maximum you may contribute is \$5,000 per calendar year, depending on your family situation. If more than one of the following situations applies to you, your maximum contribution is the lesser of the two:

- If you are a working single parent, you may contribute up to \$5,000 per calendar year
- If you are married and filing a joint income tax return, you may contribute up to \$5,000 per calendar year; if your spouse also has access to a Dependent Care FSA, your combined limit is \$5,000
- If you are married and filing separate income tax returns, you may contribute up to \$2,500 per calendar year
- If you are married and your spouse is a full-time student or disabled (defined by the IRS as physically or mentally incapable of self-care), you may contribute up to \$3,000 per calendar year for one dependent, or up to \$6,000 per calendar year for two or more dependents
- If you are married and your spouse earns less than \$5,000, you may contribute up to the amount of your spouse's annual income.

For the federal tax credit, if you're married and your spouse is a full-time student or disabled (defined by the IRS as physically or mentally incapable of self-care), you may claim up to \$3,000 a calendar year for one dependent, or up to \$6,000 a calendar year for two or more dependents.

To determine whether the Dependent Care FSA or the federal tax credit (or combination of both) is best for you, consult a tax advisor.

### ► **Your Eligibility**

To qualify, you must be at work while your eligible dependents receive care. You must also meet one of the following eligibility requirements:

- You are a single parent
- You have a working spouse
- Your spouse is a full-time student at least 5 months during the calendar year while you are working
- Your spouse is mentally or physically unable to care for him/herself
- You are divorced or legally separated and have custody of your child most of the time (even though your former spouse may claim the child for income tax purposes).

### ► **Dependent Eligibility**

Eligible dependents for this plan include children, spouse, and dependent parents:

- Your child under age 13 of whom you have custody and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with custody can consider the child an eligible dependent under this plan.
- Incapacitated parent residing in your household must reside for more than one half year.
- Your child of any age who is physically or mentally unable to care for him/herself
- Your spouse who is physically or mentally unable to care for him/herself.

### ► **Eligible Expenses**

The following types of care are reimbursable from a Dependent Care FSA:

- Care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes, or one of your children under age 19
- A dependent care center or child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations)
- A housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent

- Adult care for an incapacitated spouse or parent; this includes only the day care expenses; nursing/medical care does not qualify for reimbursement through a Dependent Care FSA, but may qualify under a Health Care FSA.

To qualify for reimbursement, you must provide your dependent care provider's tax ID number, Social Security number or claim form. If you fail to do so, your Dependent Care FSA reimbursements may be reclassified as taxable income by the IRS. You must still complete IRS Form 2441 when reporting taxes at the end of each calendar year.

You are responsible for making sure the expenses you submit for reimbursement are considered eligible expenses by the IRS. If you're not sure whether an expense is eligible, consult a tax advisor or contact FBMC.

### ► **Ineligible Expenses**

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- Books and supplies
- Child support payments or child care if you are a noncustodial parent
- Health care or educational tuition costs
- Services provided by your dependent, your spouse's dependent or your child who is under age 19
- Overnight camps and education, including kindergarten (but summer day camps are).

However, if the cost of tuition and dependent care can be separated, the itemized cost of the dependent care is reimbursable. If necessary, consult a tax advisor.

### ► **Expense Reimbursement**

To get reimbursed from a Dependent Care FSA, complete the reimbursement claim form (provided when you enroll and available from FBMC) and attach any appropriate receipts (or have the dependent care provider sign the claim form instead of a receipt). Fax or mail the information to FBMC.

When your Dependent Care FSA reimbursement request is received and approved, you are reimbursed for your eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year.

### ► **If Reimbursement is Denied**

If your request for a mid-year change to your FSA, an FSA reimbursement claim or other similar request is denied, in full or in part, you have the right to appeal the decision by sending a written request for review within 30 days of the denial to:

FBMC – Appeals Process  
P.O. Box 1878  
Tallahassee, FL 32302-1878

Your written appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- The denial letter you received
- Why you think your request should not have been denied, and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt of your appeal and supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 days. If your appeal is approved, additional processing time is required to modify your account.

Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer, insurance provider and IRS regulations governing the plan.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on.

## **Other Considerations**

### **► Health Care and Dependent Care FSAs Don't Mix**

Health Care and Dependent Care FSAs are separate. The money you allocate for one cannot be used for the other and you cannot transfer dollars between accounts.

### **► Use It or Lose It**

You may request reimbursement from an FSA through March 31 of the following year for eligible expenses incurred during the previous FSA calendar year. Your request must be received by FBMC no later than March 31 and any money left in your FSA after March 31 is forfeited in accordance to IRS regulations.

### **► FSA Contributions Can Affect Social Security**

Because you and the county don't pay Social Security (FICA) taxes on the money you contribute to an FSA, your future Social Security benefits may be reduced slightly. However, you may find that the tax savings gained through participation in an FSA outweigh any loss in benefits. Consult a tax advisor.

### **► Changes Outside Open Enrollment are Restricted**

The election you make when you enroll for an FSA remains in effect for the entire calendar year. You must re-enroll every year to participate in the FSA program. You may change your elections (begin, increase, decrease or stop contributions) during open enrollment for the following FSA calendar year or when you have a qualifying status change:

- Change in your legal marital status due to marriage, legal separation, annulment, divorce or death of a spouse
- Change in the number of your tax dependents due to birth, adoption or placement for adoption, or death of a dependent
- Change in employment status for you, your spouse or dependent due to termination or commencement of employment, reduction or increase in work hours, switch from salaried to hourly-paid/union to non-union/part-time to full-time, strike or lockout, beginning or return from unpaid leave of absence or any other change which affects benefit eligibility
- Change in the place of residence or work of you, your spouse or dependent which affects benefit eligibility
- Change that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances provided for in the benefit plans
- Change due to certain judgments and court orders
- Change in cost of dependent care due to change in provider
- Significant change in coverage or cost due to employer benefit plan changes.

You have 30 days from the date of a qualifying status change to modify your FSA election, and the change must be consistent with and on account of the status change. To make the change, you must go online at (enrollment website).

► **If You Leave Employment or Are on an Unpaid Leave of Absence**

If you leave employment you may continue to contribute in your Health Care FSA through the end of the calendar year as long as you elect continued health coverage under COBRA or retiree medical benefits. Because your contributions are not a payroll deduction, they will be post-tax contributions. You have until March 31 of the following year to submit reimbursement requests for expenses incurred during the previous calendar year while under COBRA or retiree medical benefits.

If you leave employment but don't continue your Health Care FSA under COBRA or retiree medical benefits, your contribution to your FSA ends the day you leave employment. You have until March 31 of the following year to submit reimbursement requests for expenses incurred through the date you leave.

If you leave employment, your contribution to your Dependent Care FSA ends the day you leave employment. You have until March 31 of the following year to submit reimbursement requests for expenses incurred through the date you leave.

If you go on an unpaid Leave of Absence (such as King County Family and Medical Leave or a Leave of Absence Without Pay), your contributions to your Health Care and/or Dependent Care FSAs cease. Upon your return to work in a paid status, your contributions will resume providing your paycheck is large enough for deductions.

► **A Change in Your Address**

If you change your address, update both FBMC and Benefits and Retirement Operations. You may update FBMC by contacting them by phone, fax or e-mail (see Resource Directory on page 12.) You need to update Benefits and Retirement Operations by submitting a Personal Information Update form.

► **Making Claims for Expenses Incurred In the Previous Year**

If you were previously enrolled in a Health Care FSA or Dependent Care FSA in 2006 with Personal Choice Account and need to file a claim for expenses incurred in 2006, you have until March 31, 2007, to file your claim with PCA:

The Personal Choice Account  
PO Box 3199, Portland OR 97208-3199  
Phone 1-800-334-4340  
Fax 1-800-979-8987

## Resource Directory

If no TTY phone number is listed, please call 711 to access the TTY Relay Service.

For Questions About ...	Contact ...
<p><b>Benefits – General</b></p> <ul style="list-style-type: none"> <li>▪ Eligibility</li> <li>▪ Open enrollment and making changes</li> <li>▪ Flexible Spending Account enrollment</li> <li>▪ Alternate formats of any material</li> </ul>	<p><b>Benefits and Retirement Operations</b>            EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598            Phone 206-684-1556 ▪ 1-800-325-6165 x41556 (outside local calling area)            Fax 206-684-1925            E-mail <a href="mailto:kc.benefits@metrokc.gov">kc.benefits@metrokc.gov</a>            Web <a href="http://www.metrokc.gov/employees/benefits">www.metrokc.gov/employees/benefits</a></p>
<p><b>Flexible Spending Accounts (FSAs) in 2007</b></p> <ul style="list-style-type: none"> <li>▪ Account balances</li> <li>▪ Reimbursements</li> <li>▪ Other plan details</li> </ul>	<p><b>Fringe Benefits Management Company (FBMC)</b>            P.O. Box 1878            Tallahassee, Florida 32302-1800            Phone 1-800-342-8017            Fax 1-850-850.425-4608            Web <a href="http://www.myFBMC.com">www.myFBMC.com</a></p>
<p><b>Flexible Spending Accounts (FSAs) in 2006</b></p> <ul style="list-style-type: none"> <li>▪ Account balances</li> <li>▪ Reimbursements</li> </ul>	<p><b>Personal Choice Account (PCA) offered by Regence BlueCross and BlueShield of Oregon</b>            The Personal Choice Account            PO Box 3199, Portland OR 97208-3199            Phone 1-800-334-4340            Fax 1-800-979-8987            E-mail <a href="mailto:pca@regence.com">pca@regence.com</a>            Web <a href="http://www.myflexmoney.com">www.myflexmoney.com</a></p>



**King County**

Benefits and Retirement  
Operations

# Flexible Spending Account Enrollment

Complete this form to enroll in a Health Care FSA, Dependent Care FSA or both. Return the form to Benefits and Retirement Operations, Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598 *within 30 days of when your other benefits begin*. To have FSA reimbursements direct deposited, go to [www.myFBMC.com](http://www.myFBMC.com) or call FBMC at 1-800-342-8017.

Name (print) \_\_\_\_\_ PeopleSoft Employee ID \_\_\_\_\_

Street Address or PO Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail \_\_\_\_\_ Contact Phone (\_\_\_\_\_) \_\_\_\_\_

Paid  5<sup>th</sup> and 20<sup>th</sup> each month  Every other Thursday

Effective date (*eligibility date verified by Benefits and Retirement Operations*)

Please make effective when I'm eligible (mo/yr) \_\_\_\_\_  This is my annual re-enrollment (yr) \_\_\_\_\_

## Health Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The minimum you may contribute is \$300; the maximum may not exceed \$6,000 annually. Whether you're paid 24 or 26 times per year, a maximum of 24 payroll deductions will be taken. The per paycheck deduction amount is determined by the date your enrollment is processed and made effective.

Yes, I elect to participate. Please deduct a total of \$ \_\_\_\_\_ PER YEAR from my paychecks in 200\_\_\_\_\_.

## Dependent Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The minimum you may contribute is \$300; the maximum may not exceed: 1) the lower of husband's or wife's earned income, 2) \$5,000 annually if married filing jointly or head of household or 3) \$2,500 annually if married filing separately. Whether you're paid 24 or 26 times per year, a maximum of 24 payroll deductions will be taken. The per paycheck deduction amount is determined by when your enrollment is processed and made effective.

Yes, I elect to participate. Please deduct a total of \$ \_\_\_\_\_ PER YEAR from my paychecks in 200\_\_\_\_\_.

## Authorization

*I authorize King County to withhold a portion of my pre-tax employment compensation and deposit these funds to the FSA(s) I've designated above. In consideration of King County allowing me to participate in the plan, I agree to abide by the terms, conditions and provisions of the plan contained in the county's plan document. I have been informed the plan may be modified from time to time and I agree King County may cancel or amend the plan according to its independent judgment and discretion. I understand I will be notified in advance of any changes. I acknowledge my right to examine the plan document or obtain a copy of it by giving reasonable advance notice to the plan administrator and paying a reasonable copy cost.*

*I acknowledge the Internal Revenue Code and the plan permit me to claim reimbursement only for my eligible expenses incurred after the effective date of my FSA elections. I understand the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by the plan. I assume full responsibility for all taxes, penalties, interest or other consequences, which may be assessed to or imposed on me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from the plan for disallowed expenses.*

*I choose to participate in the FSA Program with the knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) and this may reduce my Social Security benefits upon retirement.*

*I understand I must claim reimbursement for eligible expenses incurred during the calendar year on or before 90 days after the last day of the calendar year or I will forfeit those reimbursements. I further acknowledge I will forfeit all funds credited to my FSAs, which are not reimbursed to me.*

*I understand the total amount I have requested will be deducted for the year I have indicated, but my per paycheck deduction amount will be determined by when my enrollment is processed and made effective.*

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

Office Use Only	Received	Eligibility Verified	Copy to FBMC	FSA Effective Date
	Date Staff Name	Date Staff Name	Date Staff Name	

