City College of San Francisco

Enrollment Form: Flexible Spending Accounts

January 1, 2025 to December 31, 2025

☐ **NEW HIRE** ☐ **QUALIFYING EVENT** _____

Do not use this form for Open Enrollment (OE)

GENERAL INFORMATION:

Employee: _____ CCD ID #: _____

Street Address: _____

City, State, Zip: _____

Email: _____

Annual Election (January – December 31)

Health Care FSA:

Initial Annual Election $ _____

Qualifying Life Event: Additional: $_____ Reduction $_____ New Annual Election: $_____

Minimum: $50/year, Maximum: $3,300/year

Notes: If you or your spouse are enrolled in an HSA you cannot enroll in FSA. Unused amount will be forfeited at the end of the calendar year or your termination date. Up to $660 may carryover into 2026, one time.

Dependent Care FSA:

Initial Annual Election $ _____

Qualifying Life Event: Additional: $_____ Reduction $_____ New Annual Election: $_____

Minimum: $50/year, Maximum: $5,000/year

Notes: For day care expenses incurred during employment hours. Unused amount will be forfeited at the end of the calendar year or your termination date. No carryovers.

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

☐ I hereby elect NOT to participate in the Flexible Spending Accounts

_____ _____

Employee Signature Date

If you have any questions, you can email benefits@ccsf.edu or call 415-452-7733

Flexible Spending Account is administered by Wageworks

Please return this form to CCSF Human Resources – Benefits Unit 50 Frida Kahlo Way, Bungalow 702, San Francisco, CA 94112

HR Use: Deduction Code 401 (HCFSA): Effective Date: _____ **$** _____ **/pp # of pp:** _____

Deduction Code 402 (DCFSA): Effective Date: _____ **$** _____ **/pp # of pp:** _____