City College of San Francisco
Enrollment Form: Flexible Spending Accounts
January 1, 2022 to December 31, 2022

☐ New Hire   ☐ Qualifying Life Event: _____

Do not use this form for Open Enrollment (OE)

GENERAL INFORMATION:

Employee Name: _____ CCD ID #: _____

Mailing Address:_____

City: State: Zip: _____

E-mail Address: _____

Date of Birth (MM/DD/YYYY): _____   Date of Hire (MM/DD/YYYY): _____

Annual Election (January – December 31)

Health Care FSA:

Initial Annual Election $ _____

Qualifying Life Event: Additional: $_____ Reduction $_____ New Annual Election: $_____
Minimum: $50/year, Maximum: $2,850/year

Dependent Care FSA:

Initial Annual Election $ _____

Qualifying Life Event: Additional: $_____ Reduction $_____ New Annual Election: $_____
(Day care expenses incurred during employment hours)

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

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, E107, San Francisco, CA 94112

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

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