



Employee Name _____ Employee ID # _____
Please Print

Email Address _____ Mailing Address _____
Street

City State Zip

Department _____ Work/Cell Phone # _____

Participants have a one-time opportunity to enroll, cancel, increase or decrease their FSA elections at any time during the remainder of the 2021 plan year without providing a reason due to COVID-19. The new annual election amount must be equal to or greater than what a participant has contributed year-to-date and amounts already reimbursed from the plan. Refunds of contributions are not permitted.

Enrollment elections and changes are effective the first of the pay period following the date Human Resources Benefits Division receives the completed form, subject to payroll processing deadlines. **Completed forms must be received no later than August 31, 2021.** Only eligible expenses incurred during the Coverage Period or through the plans grace period (December 31, 2022) are eligible for reimbursement.

Pre-Tax FSA Benefit Election Change - 2021 Annual election amount changes will be matched to total amount of claims paid and will be limited to amounts no less than the amount already reimbursed as of the pay date change effective date.

<u>Health FSA Plan</u> – Annual Max:\$2,750	
<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel* <input type="checkbox"/> Increase <input type="checkbox"/> Decrease*
Current Annual Election Amount \$ _____	New Annual Election Amount \$ _____
YTD Payroll Contribution \$ _____	YTD ASI Flex Reimbursement Amount \$ _____

<u>Dependent Care Assistance Plan</u> – Annual Max:\$5,000 (2,500 if married filing separate)	
<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel* <input type="checkbox"/> Increase <input type="checkbox"/> Decrease*
Current Annual Election Amount \$ _____	New Annual Election Amount \$ _____
YTD Payroll Contribution \$ _____	YTD ASI Flex Reimbursement Amount \$ _____

*Electing to cancel your FSA election will result in your inability to request a reimbursement for service dates after your cancellation effective date. Cancellations are effective the first of the pay period following the date Human Resources Benefits Division receives the completed form. You can avoid this by selecting the Decrease option which will allow you to have reimbursable services throughout the plan year. When decreasing coverage, you are not allowed to decrease coverage to an amount lower than your YTD ASI Flex Reimbursement.

Authorization and Agreement

I hereby elect the benefit(s) indicated above. I have read and understand the plan provisions and I authorize the County of Riverside to deduct the elected pre-tax Annual Election Amount during the plan year. Bi-weekly contributions withheld will be based on the Annual Election Amount and the number of pay periods remaining in the plan year. If my new annual election amount is lower than my total claims paid on the pay date change effective date, I agree to have my annual election amount adjusted to the total claims paid amount and my bi-weekly contributions will be adjusted accordingly. **I understand that this election is binding and cannot be revoked or modified for the current plan year, except within 60 days of a qualifying change in family or work status event** (e.g., marriage, divorce, birth etc.). I further understand that any remaining funds that are not used for eligible expenses incurred during the **Coverage Period**, and Plan grace period, will be forfeited in accordance with the current plan provisions and tax laws.

Employee Signature _____ Date _____

Return this form to the Human Resources Benefits Division at benefits@rivco.org or fax to (951) 955-3490.