Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

MEDICAL EXPENSE REIMBURSEMENT (FSA) PLAN ENROLLMENT FORM

Select a group respective to your bargaining unit:

- ☐ **General Group 1:** General, Professional, Safety, Safety Management and Supervisory, Specialized Peace Officer Supervisory, Specialized Peace Officer, Water and Sanitation, Specialized Fire Services, Firefighters Local 935, General Fire Support, Special Districts/County Fire Non-Represented
- ☐ **General Group 2:** Nurses, Probation, Emergency Services
- ☐ **Exempt Group:** Exempt, Exempt-Special Districts/County Fire, LAFCO, Elected Officials

Must print in Blue or Black ink ONLY

TYPE OF ENROLLMENT

Check one: ☐ New Hire ☐ Midyear Change-in-Status Event (Premium Deduction Election Form required)

Employee ID	Rcd No.	Last Name, First Name	Telephone
Mailing Address, City, State, Zip Code			**Email Address**

CONTRIBUTION ELECTION

I elect to have the following amount deducted from my salary and deposited in my Medical Expense Reimbursement (FSA) Plan account during the _____ Plan Year.

$ _____ (FSA Plan contribution per pay period) x _____ (Number of pay periods *(Contact EBSD - HR for this information)*) = $ _____ (Annual FSA Plan Election)

EMPLOYEE AUTHORIZATION

I elect to participate in San Bernardino County's Medical Expense Reimbursement (FSA) Plan. I certify that I have read and agree to the terms and conditions in the Medical Expense Reimbursement (FSA) Plan Document. I understand that:

- This election is only valid for the current plan year. I must elect to enroll each year in order to continue participating in the FSA Plan.
- I may not revoke or change my election for the remainder of the plan year unless I experience a Section 125 qualifying midyear Change-in-Status event. I understand I have sixty (60) days from a qualifying Change-in-Status event to request any changes made to my annual election.
- My taxable salary will be reduced by the amount I have elected to contribute on a before tax basis. I authorize the County to deduct the specified amount above per pay period from my pay warrant.
- Medical expenses can be incurred and may be submitted beginning on the day in which my enrollment becomes effective.
- Any claimed medical care expense(s) must meet Internal Revenue Code (IRC) Section 152 and the County's Plan Document.
- Claims for eligible expenses incurred within the plan year must be submitted for reimbursement no later than the ninety (90) days run-out period and any amount unclaimed will be forfeited.
- If I am reimbursed for amounts greater than what I am entitled to during the Plan Year, I will owe the County the amount overpaid, which includes (e.g., Exempt) employer match. I authorize the County to deduct the overpayment amount from my pay warrant.

Employee (Print & Sign)	Date

Payroll Specialist (Print & Sign)	Date

DISTRIBUTION: Original
New Hire - EMACS-HR (0030)
Midyear change - EBSD-HR (0440)

HR Office Use Only

Benefit Plan ID	Benefit Plan Eff. Date	Keyed by EMACS (Employee ID)	Date	Audited by (Employee ID)	Date	Enrolled in 1Cloud
						☐

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.