2024 Flexible Spending Account (FSA) Program Enrollment Form

Employee ID:	Federal Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Legally Separated		
Last Name:	First Name:		M.I.
Street Address:	City:	State:	Zip:
Telephone:	Email:		
This form must be completed, signed and returned to County of Riverside, Human Resources, P.O. Box 1569, Riverside, CA 92502-1569, Fax: 951-955-3490, or email benefits@rivco.org no later than December 31, 2023.			

Flexible Spending Account	2024 Annual Election
Health Care Account (i.e., eligible health care expenses for you and your dependents): Elect an annual amount between $240 and $3,050	**$**
Dependent Care Account (i.e., expenses to care for eligible dependents that allow you to work): Elect an annual amount between $240 and $5,000 (Note: if you are married and filing separate income tax returns, the maximum that you may allocate to DCFSA is $2,500.)	**$**

Please read and initial each section below:

☐ I understand that by signing and submitting this Enrollment/Change Form, I am making a binding election as to my benefit coverage for the Plan Year that begins on January 1, 2024. I authorize my Employer to reduce my gross salary as indicated on this form in order to pay for the benefits I have elected. I understand that my payments will be pro-rated over each payroll period.

☐ I understand that my HCFSA election cannot be reduced or revoked for any reason except for termination of employment during the Plan Year, or if I should take unpaid leave of absence. I agree to pay, in full, the amount elected on this form for the Plan Year for HCFSA, by recalculating the payroll deductions upon returning from unpaid leave. My HCFSA and/or DCFSA election can only be changed if I experience a Qualifying Event defined by IRC125. I further understand that each account is separate and that DCFSA funds cannot be used for or transferred to HCFSA or vice-versa.

☐ I understand that any amount remaining in these FSAs that is not used during the Plan Year and HCFSA Grace Period, if applicable, will be permanently forfeited by me. I understand that I am only eligible to receive reimbursement on behalf of my eligible dependents.

☐ I understand that I will be terminated from participation in the Program if I cease employment with the County of Riverside or go on an unpaid leave of absence, unless I elect to participate in the Continuation Coverage for HCFSA.

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Signature Date