

**STATE OF MONTANA FLEXIBLE SPENDING ACCOUNT
ENROLLMENT/CHANGE
AND SALARY REDUCTION AGREEMENT FORM**

Print name & address:

	SABHRS ID	Agency Name
	Work Phone	Home Phone
	Social Security Number	Date of Birth

1. ELECTION TO PARTICIPATE – Check the box below to indicate the type of enrollment or change. I understand that I can only enroll mid-year if I am a new employee **or** have a qualifying event.

New Employee

The effective date of this Flexible Spending Account is the 1st day of the next **full month** after your health benefits are in force AND this form is received in Health Care and Benefits Division.

Current Employee with a change in election due to a Qualifying Event

Mid-year enrollments or changes for current employees can only be made if they are due to an IRS allowed change in family status that has occurred within the last 63 days (or 94 days for birth or adoption). Examples of a family status change are marriage, birth, adoption, pre-adoption, child support order, losing other group coverage, dependent death, or divorce. Note that the change must also be consistent with the change in family status (i.e. adding a dependent typically warrants an increase in contribution, not a decrease). For mid-year enrollment/changes, the effective date is the 1st day of the next **full month** following receipt of form in Health Care and Benefits Division. I certify that this enrollment/change is due to:

Qualifying Event: _____

Date of Qualifying Event: _____

2. AMOUNT OF ELECTION - List the **Monthly Election Amount (including any unused state contribution)** for your desired account(s). The minimum monthly election amount per account is \$10.00. Please elect an amount that can be divided evenly by two. **Your election will be rounded down to accommodate even deduction amounts if necessary.**

Remember "Use It or Lose It" – Set aside only as much as you think you will need. The IRS regulations require any unused contributions to be forfeited.

COMPLETE YOUR ELECTIONS

Monthly Election Amount		
<i>Make certain your election(s) are divisible by 2.</i>		
Medical Expense FSA	\$10min/\$416.66 max	/month
Dependent Care FSA (Day Care Expenses)	\$10min/\$416.66 max	/month
Administrative Fee		Currently waived
Total Monthly Election		/month

I have read the informational material describing Flexible Spending Accounts and understand the participation conditions and requirements. I request participation in the FSA(s) listed above for the current benefit year, and authorize the State of Montana to reduce gross salary by the amounts indicated or, in the event of self-paying, to pay the amount indicated. I understand that my election amount will remain in effect for the entire benefit year, and only expenses incurred during period where contributions have been made can be claimed for reimbursement. I realize that this agreement **will NOT** continue for subsequent benefit years. This agreement revokes all prior State of Montana Flexible Spending Account Enrollment/Change and Salary Reduction Agreements signed by me for this benefit year.

Employee's
Signature _____

Date _____

Administrative Use Only				
FSA Type	Monthly Election	# of Months	Yearly Election	Election Period
Medical	_____ X _____	= _____		_____ to December 31, _____
Dependent Care	_____ X _____	= _____		

Please return this form to: Health Care and Benefits Division, P.O. Box 200130, Helena, MT 59620-0130

A copy of this form will be returned to you by Health Care and Benefits Division, confirming receipt of your election.

Instructions

Maximum Elections Amounts – The maximum contribution for a **medical** flexible spending account is \$4,999.92 per year per person, not to exceed \$416.66 per month.

The maximum contribution for a **dependent care** flexible spending account is \$4,999.92 per year per household, not to exceed \$416.66 per month.

Mid-Year Enrollment (New Hire) Effective Date – Mid-year flexible spending enrollment is available to new employees during the first 31 days of employment. The effective date is the 1st day of the month following the hire date (assuming medical benefits are in force on or before this date). For example, if hired on March 15, 2011, the flexible spending account(s) will be effective April 1, 2011 and the first payroll deduction(s) will be taken on April 21, 2011 for the pay period ending April 9, 2011.

Flexible Spending Accounts are administered by:
ALLEGIANCE FLEX ADVANTAGE
(866) 339-4310
FAX: (406) 523-3149 or (877) 424-3539
www.allegianceflexadvantage.com

Change in Election or Mid-Year Enrollment for Current employees – A change in the flexible spending election can only be made in cases where a qualified family status change has occurred such as marriage, birth, adoption, pre-adoption, child support order, losing other group coverage, death, or divorce (change in state share excess is not considered a family status change). You must list the qualifying event and the date the qualifying event occurred. Record the revised monthly election amount in the “Monthly Election Amount” section of the form. Please attach documentation verifying the change (marriage certificate, birth certificate, court order, etc).

Changes to Dependent Care can also be made if child care arrangements change mid-year such as no longer needing daycare (i.e. school starting, etc.) or changing daycare providers (resulting in a change in the cost).

Changes in election may also apply in the case of an unpaid leave of absence where upon return to work, an employee chooses to revise the annual election amount.