OEA Choice Trust

SECTION 125 FSA PLAN
ENROLLMENT FORM

For Office Use Only
[x] New Enrollment [ ] Change
[x] Effective 01/01/2012
[x] ER Funding $_____

Employee Information CHECK BOX IF NEW ADDRESS ☐	Employer: Lane Community College Employee L # _____ Employee Name: _____ SSN _____ Home Address: _____ Street City State Zip Daytime Phone: ( ) _____
Job Classification	(check one) ☐ Faculty ☐ Classified ☐ Management *and* (check one) ☐ Full-time ☐ Part-time
Coverage Period	Plan year in which you are enrolling: From 01/01/2012 to 12/31/2012 Effective date for your elections under this form: January 1, 2012
Premium Payments (Optional Opt Out Election)	When you enroll for Health Insurance Plan coverage, you are automatically enrolled in the Premium Payments Program of the Section 125 Plan. The premiums you are required to pay are then deducted from your paycheck and paid on a pre-tax basis. This payment method is preferred by most people. However, if you wish, you can opt out of the Premium Payment Program. If you do, the required premiums will still be deducted from your paycheck, but on an after-tax basis. (Note the Premium Payment Program is the only way to pay your required health insurance premiums on a pre-tax basis. They cannot be claimed as a reimbursable expense from your Healthcare Expense Reimbursement Account.) Opt Out Election (optional): By signing here ➧ No Signature Required (not applicable to LCC) I elect to opt out of the Premium Payment Program.
Expense Reimbursement Accounts	Per Pay Period Amount x No. of Pay Checks You Receive In A Plan Year = Annual Amount Healthcare Expense Reimbursement $ _____ x _____ = $ _____ DO NOT INCLUDE THE EMPLOYER CONTRIBUTION AMOUNT IN THIS TOTAL. IT WILL BE ADDED SEPARATELY. The employee contribution PLUS the employer contribution cannot exceed the $3,000 annual maximum. The 2011 employer contribution is based upon the dependent(s) enrolled on your health insurance plan. Dependent Care Expense Reimbursement *(see back for maximums)* $ _____ x _____ = $ _____ Total $ _____ $ _____
Salary Reduction Agreement	Please enroll me for the benefits I have elected above. I authorize my employer to reduce my gross paycheck to pay for the coverage(s) I elected above. I have received the explanation of my options under the Section 125 Plan and I have read the coverage conditions listed on the back of this form. x Employee Signature Date
Waiver of Coverage *(optional)*	By signing here x Do not sign here (not applicable to LCC) Employee Signature Date I acknowledge that the Section 125 Plan has been offered to me and I elect not to participate.

COVERAGE CONDITIONS

In consideration of my employer allowing me to participate in the Flexible Spending Account (FSA), I acknowledge and agree to the following:

ACCEPTABLE FSA TERMS:
I agree to abide by the terms, conditions, and provisions of the FSA contained in my Employer's Plan Document. I acknowledge my right to examine the Plan Document or to obtain a copy of it by giving reasonable advance notice and paying a reasonable cost.

RESPONSIBILITY:
I acknowledge that the Internal Revenue Code permits me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my FSA elections and I assume full responsibility for all taxes, penalties, interest, or other consequences which may be assessed to me by any state, federal, or other governmental taxing authority as a result of my requesting and receiving reimbursement from the FSA for disallowed expenses.

SOCIAL SECURITY:
I choose to participate in the FSA despite my knowledge that my salary reduction elections may reduce my FICA withholding (Social Security) and that this may reduce my Social Security benefits upon retirement.

IRREVOCABLE ELECTION:
I understand I cannot change or revoke my election until the open enrollment period for the new plan year. I will be able to change my election if I have a change in status as outlined in the Plan Document. The election change must be requested within 30 days of the event and must be on account of, and consistent with, the change in status.

PLAN MODIFICATIONS:
I have been informed that the FSA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the FSA according to their individual judgment and discretion without my consent or prior notice to me.

FORFEITURE:
I understand that I must claim reimbursement for eligible expenses incurred during the plan year within 90 days of the last day of the plan year. Otherwise, I understand that I will forfeit those reimbursements. I further acknowledge that I will forfeit all funds credited to my FSA accounts which are not reimbursed to me.

SEEK LEGAL ADVICE:
I have been informed that my participation in the FSA will have tax and economic consequences to me and that before deciding to participate in the FSA, I should seek the advice of an attorney or tax consultant regarding the benefits, risks, and limitations of the FSA.

DEPENDENT CARE:
I understand that the Internal Revenue Code prohibits me from claiming the Federal Child Care Credit for dependent care assistance expenses which are reimbursed to me by the FSA. The maximum amount I can claim depends on how I file my tax returns. If I am married filing jointly, or single, the maximum is $5,000. If I am married filing separately, the maximum is $2,500.

OEA Choice Trust