THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING COMMISSION

6611 Kenilworth Avenue, Riverdale, Maryland 20737

2026 Flexible Spending Account Election Form

EMPLOYEE INFORMATION

Name	Employee ID
Phone Number	Work Location

ELECTION INFORMATION:	**Amount Per Pay Period (Minimum $10)**	**OR**	**Annual Election**	**Minimum Allowed**	**Maximum Allowed**
☐ Health Care Reimbursement (for Health Care expenses)	_____		_____	$260	$3,300
☐ Dependent Care Reimbursement (for Day Care expenses)	_____		_____	$260	$7,500

NOTE 1: In the event of a calculation discrepancy, the amount per pay period will be the amount used, and the annual election amount will be recalculated. If the recalculated amount exceeds $2,850 or $5,000, the amount per pay period will be adjusted.

NOTE 2: If you are married and filing separately, your dependent care maximum is $2,500.

QUALIFIED LIFE EVENT CHANGE

Date of Event: ____/____/____

- ☐ Open Enrollment
- ☐ New Hire/Rehire
- ☐ Change in Day Care providers/School Closure
- ☐ Loss of dependent status
- ☐ Marriage / Divorce
- ☐ Change in employment status of employee or spouse
- ☐ Birth/Death of spouse or dependent
- ☐ Unpaid leave of absence by employee or spouse
- ☐ Termination of Employment or Retirement
- ☐ Other_____

DIRECT DEPOSIT for REIMBURSEMENT: You may enroll for direct deposit of your reimbursements by registering on Benefit Strategies' website at www.benstrat.com.

I elect to participate in the M-NCPPC's Flexible Spending Account for the above indicated Plan Year. I understand that I must re-enroll each year. I authorize the health vendors to provide claim information to the Commission's flexible spending account administrator in connection with debit card claims and administration. Proof of the qualifying event must be submitted with this form before any change can be made. Any prior plan year form will not be accepted for the current plan year. If I retire or terminate before the end of the calendar year, I will be reimbursed only for expenses incurred prior to separation date, unless I elect to continue the plan under COBRA on a post-tax basis. I have 90 days from separation date to submit expenses for reimbursement. **Any overpayment made to me may be recovered through payroll deduction or annuity payment.**

I have read and I agree to the terms and conditions set forth on both sides of this form.

Employee Signature: _____

Date _____

HEALTH & BENEFITS ONLY	**DATE**	**INITIALS**
Received		
HRIS		
Effective Date		
Verified		

As a participant, I understand that:

1. I cannot change or revoke this agreement at any time prior to the next plan year unless I have a change in family status as described in the Summary Plan Description.
2. Deductions from my salary will occur for the remainder of the calendar year, unless this agreement is amended or terminated due to a qualifying life event.
3. The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy compliance with the Internal Revenue Code.
4. Only my child(ren) under the age of 13 or a child(ren) 13 years or older who is disabled is/are eligible for dependent care reimbursement. If a child turns 13 during the plan year only expenses incurred before he or she turned 13 will be covered. You may change election amount within 45 days of child reaching age 13.
5. I have until March 15th of the year following plan year to use any remaining funds in the prior year account(s).
6. I will have until March 31st following the end of the plan year (in 2020 extended to June 30, 2020) or **90 days following my termination** of employment to submit receipts for expenses incurred during the plan year. If I terminate, all expenses must be incurred prior to my termination, unless I elect to continue after-tax payments to the plan after my termination.
7. I agree on demand to indemnify and reimburse the Commission for any non-qualifying or non-eligible expenses reimbursed or for any overpayment made. If retired I authorize the Commission to request deduction from my annuity check.
8. If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount in accordance with IRS regulation.
9. If I am married, to be eligible for the dependent care FSA, I affirm that my spouse is working, going to school full time, or is incapable of self care. From the point in time that this situation changes, I understand I will be ineligible to further participate in the dependent care FSA.
10. This authorization is binding for the entire plan year, unless I terminate my employment or experience an eligible family status change. If I experience a Qualified Life Event Change and want to make a change to my elections, I understand that I must submit a change form within 45 days to the Health & Benefits office.
11. If my spouse elects to participate in his/her employer plan, I/we are responsible for making sure we do not exceed the IRS limit of $5,000 per family or $2,500 per person for dependent care or health care. If we do, my spouse is required to make a change in his/her election status plan. No change will be made in the M-NCPPC plan.
12. I have read the Commission's information on this plan in the Employee Benefits Handbook including the definition of a dependent.
13. **The FSA administrator nor M-NCPPC shall have any liability for any erroneous payment arising out of my failure to notify the FSA administrator of a lost or stolen spending account card or my termination as a participant in the FSA Plan**.

RETURN THIS FORM BY EMAIL TO THE HEALTH & BENEFITS OFFICE: Benefits@mncppc.org or fax: 301-454-1687.