Scott County Fiscal Court
CAFETERIA PLAN ENROLLMENT FORM
01.01.2024 - 12.31.2024

HR/Payroll Please Complete:
Payroll deductions begin: _____
Effective Date of Coverage: _____
Date of Hire: _____

Employee Information

Employee: _____ SSN: ___ - ___ - ___

Address: _____ Email:* _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Date of Hire: _____

** Putting an email address on file will allow us to send monthly electronic statements and communication regarding debit card transactions.*

Pay Frequency: □ Weekly □ Bi-Weekly □ Semi-Monthly □ Monthly

Plan Elections of Pre-Tax Reimbursement Accounts

HEALTH CARE FLEXIBLE SPENDING ACCOUNT
Out-of-pocket medical, dental and vision expenses.
Annual contribution limits: Maximum $3,050 (Please write Max if you would like to automatically adjust with the limits)

Do you elect to participate?
□ Yes □ No

Election Amount: $_____ per pay period, for a total of $_____ for plan year.

DEPENDENT (CHILD) CARE REIMBURSEMENT ACCOUNT
Child and/or adult daycare expenses.
Annual contribution limits: Maximum$5,000
(If you are married and file separate tax returns, limit is $2,500)

Do you elect to participate?
□ Yes □ No

Election Amount: $_____ per pay period, for a total of $_____ for plan year.

DIRECT DEPOSIT - To receive reimbursement for paper/manual claims directly to your bank account via ACH.

DIRECT DEPOSIT INFO WILL REMAIN THE SAME UNLESS IT IS IT IS UPDATED VIA THE ONLINE PORTAL

*I understand that if I do not choose to sign up for direct deposit as the reimbursement method for manual/paper claims, I may be responsible for a $32 stop payment fee for any lost or stolen checks.

DEBIT CARD AUTHORIZATION: ☐ Yes, I would like to receive a ***NEW*** benefits debit card to access my FSA Accounts.

If this is not for a new account there will be a $10 fee for replacement cards.

(Current card holders, please do not discard your debit card until the expiration date)

*I understand the card must only be used to pay for eligible medical and/or dependent care expenses as defined by the IRS. I understand that in some cases, I may still be required to submit proper documentation to substantiate my purchases.

Participant Authorization

I hereby authorize my Employer to deduct from my salary the required contributions for the amounts I have elected above. I agree and understand that I cannot change my election once the plan year begins unless I experience a qualifying event as defined under the Plan and by the Internal Revenue Code (IRC). I agree to comply with the terms of the Plan, which are reflected in the Summary Plan Description (SPD). I acknowledge I have received and read all of the information provided on page 2 of this Form.

Employee Signature: _____ Date: _____

*Please review important information on page 2.

GROUP HEALTH INSURANCE COVERAGE AUTHORIZATION:

I understand that:

If I choose to participate in any group health plan and I am required to pay a portion of the premium, this amount is automatically deducted pre-tax. If I do not wish to have my premiums deducted pre-tax, I must obtain a waiver from my Human Resources Department. I may not change my coverage election during the plan/policy year unless I experience a qualifying event as defined by the Cafeteria Plan and the Internal Revenue Code (IRC).

FLEXIBLE SPENDING ACCOUNTS AUTHORIZATION:

I understand that:

I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year. I must submit my claims, incurred during the current Plan Year, by the end of the "run-out" period. Amounts of $550 or less remaining at the end of the plan year may rollover into the subsequent plan year, pending any claims submitted during the "run out" period. Any additional funds above the $550 remaining will be forfeited at the end of the "run-out" period.

I cannot change my election once the Plan Year begins; my elections must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or a change in employment status.

My out-of-pocket expenses must be incurred while I am an eligible participant and the expenses must be incurred during the current plan year to be eligible for reimbursement. The date of service, not the Invoice date, must be incurred during the current plan year.

If I terminate employment, I can only be reimbursed for expenses incurred during the current plan year and prior to my termination date. I may have additional time to submit my claims after my termination date if the Plan allows.

I cannot itemize and deduct my out-of-pocket expenses on my IRS Form 1040 for any accounts I am enrolled.

DIRECT DEPOSIT AUTHORIZATION:

I understand that:

If I have chosen to receive payments for my reimbursement accounts via direct deposit, I authorize my financial institution to receive transactions via electronic transfer initiated by McGregor & Associates, Inc.

I permit McGregor & Associates, Inc. to initiate electronic credit entries, and if necessary, debit entries to reverse erroneous credits to the account I designated on this Form.

Direct Deposit of my reimbursements shall commence within 4 weeks of receipt of this Form.

My direct deposit may be terminated by: a written cancellation request submitted by me at least 7 business days prior to the next scheduled deposit date, a failed bank transmittal due to incorrect bank information provided by me, or by logging into my online web portal via www.mcgregoreba.com.

McGregor & Associates, Inc. reserves the right to charge a $32 fee for any failed or returned transmittal due to incorrect bank account information provided by me.

DEBIT CARD AUTHORIZATION:

I understand that:

As a participant in the Flexible Spending Accounts sponsored by my Employer, I may choose to receive a benefits pre-paid Visa debit card. I agree to use the card in accordance with this Agreement and the Cardholder Agreement that will be received with the card. There is a $10 lost card replacement fee that will be debited from my FSA account.

I understand that the benefits card is restricted to certain merchant categories and is not accepted at all Visa locations. I understand that I may not obtain a cash advance with the card at any merchant, bank or ATM. I understand that the benefits card is to be used exclusively for qualified expenses as defined by the Plan in which I participate. If the card is used for an expense that is not a qualified expense, I am indebted to my Employer and must repay the full amount of the non-qualified expense.

I agree to save all invoices and receipts related to any purchases made with my benefits card and upon request, I must submit these documents for review by McGregor & Associates, Inc. Failure to submit the requested receipt(s) within the timeframe allotted, will result in suspension of my card use. In the event I fail to supply the appropriate documentation, I understand the expense will be treated as a non-qualified expense and I will be required to repay the amount to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, or a post-tax deduction from my paycheck. I understand that my Employer reserves the right to withhold any ineligible or unsubstantiated expenses from my paycheck post-tax.

If I terminate employment, or lose eligibility under the Plan, my benefits card will become inactive.