Flexible Spending Account
ENROLLMENT FORM

To be submitted by employer.

Company Name: Santa Monica Community College District **Location:** N/A

Employee Name: _____ SSN: _____

Employee Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Plan Year: 2025 through _____

Date of Birth: _____ Date of Hire: _____ Effective Date: 01/01/2025

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (*or during such portion of the year as remains after the date of this agreement*). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay non-reimbursable medical, dependent care, and/or commuter expenses (if any) with aftertax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

Medical Flexible Spending Account

Full Flexible Spending Account

$ _____ Maximum ANNUAL Contribution

~~Per pay contribution~~: $ N/A ~~Date of first payroll~~: N/A

~~Annual contribution~~: $ N/A ~~Number of remaining pays.~~ N/A

~~**Limited Purpose Flexible Spending Account** *(i.e., vision and dental only)*~~

$ N/A ~~Maximum ANNUAL Contribution~~

~~Per pay contribution~~ $ N/A ~~Date of first payroll.~~ N/A

~~Annual contribution: $~~ N/A ~~Number of remaining pays.~~ N/A

Dependent Care Spending Account

$ _____ Maximum ANNUAL Contribution

~~Per pay contribution: $~~ N/A ~~Date of first payroll.~~ N/A

~~Annual contribution: $~~ N/A ~~Number of remaining pays.~~ N/A

Commuter Reimbursement Account

P A R K I N G

$ _____ Maximum MONTHLY Contribution

~~Per pay contribution: $~~ N/A ~~Date of first payroll.~~ N/A

~~Annual contribution: $~~ N/A ~~Number of remaining pays.~~ N/A

T R A N S I T

$ _____ Maximum MONTHLY Contribution

~~Per pay contribution: $~~ N/A ~~Date of first payroll.~~ N/A

~~Annual contribution: $~~ N/A ~~Number of remaining pays.~~ N/A

I U N D E R S T A N D T H A T:

(1) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

(2) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status (*including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election*). Note: This does not apply to Commuter Reimbursement Accounts.

(3) The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s). By signing this form I agree to the terms and procedures listed herein.

☐ **I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.**

Employee Signature **Date**

~~*Please fax or email this form to:* **Ameriflex** **Fax:** 800.282.9818 **Email:** forms@myameriflex.com~~

Flexible Spending Account Enrollment Form

ADDITIONAL CARDS *(only applicable if your employer has chosen this option)*

If you wish to have an Ameriflex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meets the IRS eligibility guidelines below:

(1) For federal tax purposes, a spouse includes all legally married same-sex or opposite-sex spouses, regardless of state residence.

(2) A "dependent" generally includes any relative of the participant for whom the participant provides over half of their support for the calendar year. A relative includes children, parents, stepchildren, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be a certain age or infirmity, they need only to be persons for whom the participant has provided over half of their support.

Spouse Name: _____

Address to issue card: _____

Telephone: _____ SSN: _____ Date of Birth: _____

All dependents must be age 18 or over in order to receive the Ameriflex Convenience Card®. If you previously added a dependent onto your plan, they will automatically be linked each year. It is your responsibility to add and/or remove dependents as needed. To add additional dependents or to remove dependents, please complete the section below.

Add ☐ Term ☐ Dependent Name: _____

Address to issue card *(if different from participant)*: _____

Telephone: _____ SSN: _____ Date of Birth: _____

Add ☐ Term ☐ Dependent Name: _____

Address to issue card *(if different from participant)*: _____

Telephone: _____ SSN: _____ Date of Birth: _____

Each Ameriflex Convenience Card® is issued for a term of three years. Remember that existing cardholders will not receive a new card (unless the current card is scheduled to expire). Cards will simply be "reloaded" for the next plan year with your new election. Upon expiration, Ameriflex will automatically issue new cards to participants who re-enroll in the new plan year. For new participants, your Ameriflex Convenience Card® will be sent to your home adress in a plain white envelope.

Employee Signature **Date**

Please fax or email this form to: **Ameriflex** **Fax:** 800.282.9818 **Email:** forms@myameriflex.com