Troy School District

Important Information Regarding Your Flexible Spending Account(s) and Open Enrollment

1/1/2017– 12/31/2017 Plan Year

The 2016 Flexible Spending Account (FSA) plan year is quickly coming to a close. If you wish to participate in the 2017 plan year, please complete the enclosed enrollment form and return it by the end of open enrollment. Below you will find some reminders about the current plan year, upcoming open enrollment period and new plan year.

2016 Plan Year (1/1/2016 – 12/31/2016):

- **Plan Year** – The plan year ends on December 31st, 2016; therefore all eligible expenses must be incurred on or before 12/31/2016 in order to be eligible for reimbursement from the 2016 plan year.
- **Run Out Period** – You have 60 days, or until February 28, 2017 to submit reimbursement claims for those expenses that incurred during the 2016 plan year.
- **Remaining Balance** – If you wish to determine the balance remaining in your FSA account(s) you can login to NGE's online system to verify this information or download the NGE Anytime Mobile App for Android, iPhone, or iPad devices. Remember that your FSA is a tax- free benefit; therefore you must use your remaining balance before the end of the plan year to avoid forfeiting the remaining balance.
- **Termination Run Out** – Should you terminate employment, you have 60 days from the date you terminate to submit claims incurred prior to your termination date.

2017 Plan Year (1/1/2017 – 12/31/2017):

Open Enrollment – Included with this letter is your FSA enrollment form for the upcoming plan year. All elections must be completed no later than the end of open enrollment.

Types of Accounts available through this plan:

- **Health Care FSA Maximum Election** – $2,600.00
- **Dependent Care FSA Maximum Election** – $5,000.00

Features of this plan:

- **Payroll Deductions** – Deductions for health and dependent care will begin with the first paycheck following the beginning of the new plan year.
- **Direct Deposit** – If you would like to have manual claim reimbursements directly deposited into your bank account, please download the Direct Deposit form found on our website www.ngeinfo.com in the forms library.
- **Debit Card** – Please do not discard your current Benefits MasterCard. Effective 1/1/2017 it will be loaded with your 2017 annual election. If you are a new participant in the plan, you will receive a Benefits MasterCard shortly before January 1st. Please be aware that you must retain copies of the receipts from your debit card purchases. Throughout the year you may be asked to provide a copy of your receipt to substantiate your debit card purchase.

Did You Know?

- **NGE Anytime** – NGE has a mobile app that you can download for use on any Apple or Android device. Just search for **Next Generation Enrollment** in the application store and you will see the app. This app will allow you to check your balance, review recent transactions, and even submit claims online by simply taking a picture of your receipt.

- **The FSA Store** – NGE has partnered with The FSA Store. Please visit our website for a direct link to the online store where you will be able to use your FSA funds to purchase FSA tax eligible items to be delivered directly to your home.

Next Generation ENROLLMENT, INC

Questions? Please contact Next Generation Enrollment at (888) 266-1732. Monday through Friday between the hours of 8:00 AM and 8:00 PM EST or visit our website at www.nextgenerationenrollment.com.

Flexible Spending Account Election Form

Please select payroll deduction preference: 21 pays ☐ 26 pays ☐

SECTION 1: EMPLOYEE CONTACT INFORMATION

EMPLOYEE NAME: LAST | FIRST/MIDDLE INITIAL | LAST FOUR DIGITS OF SOCIAL SECURITY NO.

COMPANY NAME | EMAIL ADDRESS ☐ check if new | DAYTIME PHONE NUMBER

HOME ADDRESS: STREET ☐ check if new | CITY | STATE | ZIP

SECTION 2: ELECTION INFORMATION

Health Care

☐ I elect to participate in the Healthcare Reimbursement Plan.

$_______________ is my PRE-TAX annual election amount.

☐ I elect NOT to participate.

Dependent Care

☐ I elect to participate in the Dependent-Care Reimbursement Plan.

$_______________ is my PRE-TAX annual election amount. *(Maximum amount cannot exceed $5,000 annually. Maximum cannot exceed $2,500 annually for an employee that is married and filing a separate tax return).*

☐ I elect NOT to participate.

Benefit MasterCard

☐ I would like to receive one additional Benefit MasterCard for use by an eligible dependent.

DEPENDENT NAME: LAST | FIRST | MIDDLE INITIAL

LAST FOUR DIGITS OF SOCIAL SECURITY NO. | DATE OF BIRTH

By signing this form, I understand that I am authorizing funds to be taken from my paycheck on a PRE-TAX basis and transferred into my Flexible Spending Account. The amount that I am requesting to be deducted will reduce my annual taxable wages. I understand that my election cannot be changed during the plan year unless I experience a qualifying change in status and that I am only eligible to participate in this plan year if I sign and date this enrollment form prior to my effective date of coverage under the plan.

X

EMPLOYEE SIGNATURE VERIFICATION | DATE

SECTION 3: DIRECT DEPOSIT INFORMATION (PLEASE BE ADVISED A COPY OF CANCELLED CHECK IS REQUIRED WITH THIS FORM IN ORDER TO REIMBURSE BY DIRECT DEPOSIT)

DEPOSITORY NAME | BRANCH

CITY | STATE | ZIP

ROUTING NUMBER | ACCOUNT NUMBER | ACCOUNT TYPE

I hereby authorize Next Generation Enrollment, Inc., hereinafter called COMPANY, to initiate credit entries to my account indicated above at the depository financial institution named above, hereinafter called DEPOSITORY, and to credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X

EMPLOYEE SIGNATURE VERIFICATION | DATE

SECTION 4: AUTHORIZATION TO USE OR DISCLOSE IDENTIFIABLE HEALTH INFORMATION

I, ____________________________, authorize the use and disclosure of all identifiable health information pertaining to reimbursements I file under the flexible benefits plan by or to my spouse or personal representative, ____________________________________. The disclosure of identifiable health information may be made at the request of this individual. This authorization is valid during the plan year for which I am electing to participate in the Flexible Benefits Plan. I understand that I do not have to sign this authorization to be eligible to participate in the Flexible Benefits Plan and I also understand that at any time I have the ability to revoke this authorization.

X

EMPLOYEE SIGNATURE VERIFICATION | DATE

X

SIGNATURE OF SPOUSE OR PERSONAL REPRESENTATIVE | DATE

FOR EMPLOYER USE ONLY:

Employee Division_______________Effective Date_______________Plan Year Start Date_______________End Date_______________Date of first paycheck under the plan