MISSISSIPPI STATE UNIVERSITY
Flexible Spending Account
Agreement
CAREFLEX and/or MEDIFLEX

Name: _____ **MSU ID No:** _____
(Please Print)

I elect to participate in the Flexible Spending Account (unreimbursed medical and/or dependent care) Plan(s) offered as an option under the University=s Pre-tax Benefit Plan as provided under Section 125 of the Internal Revenue Code. I understand that I should obtain additional information about these plans by reading the Mississippi State University Cafeteria Summary Plan Description.

Information regarding qualifying expenses may be found at the Third-Party Administrator's website provided through the Human Resources Management website, www.hrm.msstate.edu. I am aware that I should consult my personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if I have any doubts.

I understand that any election made under the Flexible Spending Account Plan herein is irrevocable and may be changed only during the annual benefit enrollment period or in the event of a change in family status. Family status changes must be made within 60 days of the qualifying event. I understand that if changes are not made by January 1, then I will be treated as having continued the same election in effect for subsequent plan years (January 1-December 31). I am aware that any expenses paid through the Flexible Spending Account Plans are no longer eligible for deductions for federal or state income tax purposes and participation may reduce my future social security entitlements.

MEDIFLEX – Unreimbursed Medical Expenses (URM)

I understand that an "Eligible Expense" means any item for which I could have claimed a medical expense deduction on an itemized federal income tax return (without regard to any threshold limitation) for which I have not otherwise been reimbursed from insurance, or some other source. I further understand that premiums for accident or health insurance coverage under any other plan are not Eligible Medical Expenses. Also, expenses for long-term care services are not eligible.

I understand that the amount credited to my Mediflex account for any plan year will be used only to reimburse me for qualifying medical expenses incurred during the plan year including the grace period (two and a half month extension period after the plan year ending date approved by the IRS), and only if I apply for reimbursement by or before April 15 immediately following the close of the plan year.

If any balance remains in my Mediflex account at the end of any URM benefit period and after all reimbursements have been made, such balance will be forfeited by me. Any funds remaining in my Mediflex account that were not claimed by or before April 15, immediately following the close of the plan year will be forfeited.

I understand if I elect the High Deductible Health Plan I will be eligible to participate in a Health Saving Account. I understand if I elect to participate in a Health Savings Account it will be my responsibility to open a trust account.

Also, I understand if I choose to participate in a Medical Reimbursement Account with Mississippi State University, I **cannot** participate in a Health Saving Account. If I continue the High Deductible Health Plan, this will remain in effect for subsequent years.

CAREFLEX – Dependent Care

I understand that expenses incurred for the care of a dependent are eligible for reimbursement under Careflex only if these expenses are paid so that a single parent or a married couple can work/attend school full-time or look for a job. I am able to answer yes to one of the following statements. ***(Please check the one that applies)***

- ☐ I am a single parent.
- ☐ I am married and my spouse also is employed.
- ☐ I am married and my spouse is actively seeking employment.
- ☐ I am married and my spouse is a full-time student.

I understand that the maximum amount I can elect cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. **(*Please check the one that applies)***

I qualify for the maximum amount of **$5,000** per Plan Year because:

- ☐ I am married and file a joint return.
- ☐ I am married, but I furnish more than one-half the cost of maintaining those dependents for whom I am eligible to receive tax-
  - o free reimbursements under the dependent care expense reimbursement plan (DCR), my spouse maintains a separate
  - o residence for the last six months of the calendar year, and I file a separate tax return.
- ☐ I am single, or a head of household for tax purposes.

I qualify for the maximum amount of **$5,000** per Plan Year because:

- ☐ I am married, reside with my spouse, but file a separate federal income tax return.

I qualify for the maximum amount of **$5,000** per Plan Year because:

- ☐ I am married and my spouse is a full-time student.

I further understand that the primary purpose of expenses for care of a qualifying individual must be to assure his or her well-being and protection. Expenses for food, clothing, and education are not considered eligible. Overnight camps and registration fees are not eligible expenses. I also am aware that the dependent childcare must be for children under the age of 13 years. I know that kindergarten is not an allowable expenditure.

I understand that the amount credited to my Careflex account for any plan year will be used only to reimburse me for qualifying dependent care expenses incurred during the plan year, and only if I apply for reimbursement by or before April 15 immediately following the close of the plan year. I also am aware that the dependent care account is not a pre-funded account; in other words, money must be in the account in order for me to receive reimbursement. I am aware that the grace period (two and a half month extension period after the plan year ending date) does not apply to Careflex.

If any balance remains in my Careflex account for any plan year after all reimbursements have been made, such balance will not be carried over to reimburse me for qualifying dependent care expenses incurred during a subsequent plan year, but will be forfeited by me. Any funds remaining in my Careflex account that were not claimed by or before April 15, immediately following the close of the plan year will be forfeited.

FLEXIBLE SPENDING ACCOUNT ELECTION

The Flexible Spending Account annual amount is calculated by the semi-monthly amount entered below times the number of paychecks you receive. (12 month employee receives 24 paychecks; 9 month employee receives 24 or 18 paychecks, depending on your faculty pay agreement election) If you are making a mid-year change, please take into account the flex deductions already deducted from your prior paychecks during the plan year.

If you participate in a Flexible Spending Account Plan(s), all reimbursements will be made via direct deposit. If you have not already done so, you must complete an SABC Flex Direct Deposit Form available on Human Resources Management website, www.hrm.msstate.edu.

MEDIFLEX – Unreimbursed Medical Expenses

I elect to have $_____withheld SEMI-MONTHLY **Not to exceed $3,300 annual limit**

CAREFLEX – Dependent Care

I elect to have $_____withheld SEMI-MONTHLY **Not to exceed $5,000 annual limit**

Reason for election:

☐ New Employee Date of Hire: _____

☐ Family Status Change Qualifying Event: _____

Date of Qualifying Event: _____

☐ Open Enrollment Pay Period: ☐ 24/24 ☐ 18/24 ☐ 18/18

Payroll Effective Date: _____

Name: _____ MSU ID No: _____
(Please Print)

Mailing Address: _____ Date of Birth: _____

_____

I agree my salary will be reduced by the amount(s) shown above for my flexible spending account election(s). This election and salary reduction agreement is subject to the terms of my employer's Cafeteria Plan Document. I have read and understand the information provided in this document.

Signature: _____ Date: _____

NOTE: CLAIMS MUST BE FILED BY APRIL 15 OF THE FOLLOWING CALENDAR YEAR

FLEXIBLE SPENDING ACCOUNT CANCELLATION

☐ I hereby elect to **cancel** my **MEDIFLEX** Flexible Spending Account Plan.

☐ I hereby elect to **cancel** my **CAREFLEX** Flexible Spending Account Plan.

Payroll Effective Date: _____

Name: _____ MSU ID No: _____
(**Please Print**)

Signature: _____ Date: _____
SIGN ONLY IF CANCELING COVERAGE