State of Hawaii

Island Flex Flexible Spending Accounts

Compensation Reduction Agreement

For Plan Year: July 1, 20___ to June 30, 20___

Please type or print clearly.

Section A: EMPLOYEE INFORMATION

Last Name	First	Middle	Social Security Number (Required)

Mailing Address	City/State	Zip Code	Home Phone Number

Department	Date of Birth	EMAIL Address:	Work Phone Number

Check here if this is a new address ☐

- Are you a new hire to the State? ☐ Yes ☐ No If YES, please indicate Date of Hire:_____
- Are you planning to terminate/retire prior to end of plan year? ☐ Yes ☐ No If YES, please specify date. _____/_____/_____

- **Would you like Direct Deposit?**
  - ☐ **Yes**
  - ☐ **No**

  Note: If NBS doesn't have your banking information on file already, please complete and submit a direct deposit form.

- **Would you like to elect a Debit Card for your Medical Spending Account?**
  - ☐ **Yes**
    - ☐ **I currently have a debit card – please renew**
    - ☐ **I had a card – please re-issue a new one**
    - ☐ **I do not have a card – please issue**
  - ☐ **Waive card option**

Section B: DEPENDENT/CHILD CARE SPENDING ACCOUNT

Complete this section only if you wish to enroll in the Dependent Care Spending Account to cover eligible **baby sitter, pre-school, after school care, etc., expenses.**

I elect to enroll in the ***Dependent Care Spending Account*** and authorize the following to be deducted from my paycheck on a pre-tax basis for the plan year:

$_____ Annual Amount

Maximum amount $5,000 - If you enroll in the Dependent Care Spending account only, the administration fee will be added to the amount you elect up to a total of $5,000.00.

If enrolling after July 1st, designate amount to be deducted for remainder of plan year.

Section C: MEDICAL SPENDING ACCOUNT

Complete this section only if you wish to enroll in the Medical Spending Account to cover eligible medical, dental, orthodontic care, prescribed drugs and vision expenses which aren't covered by your health insurance plans.

I elect to enroll in the ***Medical Spending Account*** and authorize the following to be deducted from my paycheck on a pre-tax basis for the plan year:

$_____ Annual Amount

Maximum amount $2,400 - The administration fee will be added to the amount you elect.

If enrolling after July 1st, designate amount to be deducted for remainder of plan year.

- I hereby authorize the State of Hawaii to reduce my gross salary (before federal, state, and Social Security taxes are calculated) by the total amount indicated above.
- I understand it is my responsibility to review: 1) the administrative rules found at www.dhrd.hawaii.gov; 2) the ***Island Flex*** Employee Informational Booklet (Plan Document); and 3) the information on page 2 of this form prior to enrolling.
- I understand that failure to exhaust flexible spending account funds within prescribed time limits will result in forfeiture of funds (with the exception of the $500 carryover for the Medical Spending Account).
- I have been given the opportunity to talk with a plan representative from National Benefit Services, LLC.

Section D: EMPLOYEE SIGNATURE:	Date:

Return the completed form to: **National Benefit Services, LLC (NBS)**

Address: 1314 S King St, Suite 326
Honolulu, HI 96814
Fax: 808-465-3712
Email: islandflex@nbsbenefits.com **(FOR ENROLLMENT USE ONLY)**

Please keep documentation of your enrollment form submission. If your original submission does not make it to NBS, you will be required to show proof that it was submitted on time in order to be enrolled. If you do not receive a confirmation letter 2-3 weeks after open enrollment ends, or, if you are enrolling mid-year, within 2 weeks of submission of your enrollment form, please contact NBS to confirm your enrollment.

Instructions for Completing the Compensation Reduction Agreement

Section A: **Employee Information -** Complete all of Section A.

Section B: **Dependent Care Spending Account** – Complete only if you wish to enroll in the Dependent Care Spending Account

Section C: **Medical Spending Account** – Complete only if you wish to enroll in the Medical Spending Account.

Section D: **Employee Signature** – Sign and date this section.

Return the completed form to: National Benefit Services (NBS)

Plan Highlights

I understand that with the **Dependent Care** and **Medical Spending Accounts:**

- I must pay a monthly administration fee to participate. The fee will be deducted from my paycheck on a BEFORE-TAX basis. Whether I participate in one or both flexible spending accounts there will be one monthly fee.
- If I only have rollover funds and am not currently contributing, the monthly fee will be withheld from my rollover balance instead of deducted from my paycheck.
- My election is **irrevocable** for the plan year, unless I have an allowable status change. Examples of allowable status changes include, but are not limited to: changes in legal marital status, changes in the number of dependents, and changes in employment status.
- The election change must be consistent with the status change and may be made on a **prospective** basis only after NBS's receipt and approval of the required status change forms.
- I must submit a written status change form to NBS within 90 days of the status change event. Otherwise, my election cannot be changed.
- My accumulated receipts must total at least $25 before I am reimbursed on my claim. The only exception is at the end of the plan year if my available balance is less than $25, or if I mark my last claim as "FINAL CLAIM."
- **I will have until September 30th following the end of the plan year to file claims for expenses incurred during the plan year.**
- All receipts must contain complete information before my reimbursement can be processed, and this should be submitted before September 30. Otherwise, **corrected claim forms (i.e., additional or follow-up supporting documents) received after September 30 shall not be reimbursed.**
- I will inform NBS when I go out on any leaves of absence without pay or if I terminate my employment with the State.

I understand that with the **Dependent Care Spending Account**:

- Dependent care expenses are reimbursable if my spouse (if I am married) and I are both employed or if my spouse is a full-time student.
- I may not claim for services for periods I (or my spouse if I am married) did not work or while not on duty, (e.g., leaves of absence, vacation, sick leave, etc.).
- Dependent care expenses must be for my dependent child under age 13 or other dependents (e.g., a physically or mentally handicapped relative or other person living in my home who is unable to care for himself/herself and over half of whose support I pay).
- I can contribute up to $5,000 per year if I am a single parent, or married and filing a joint return. This maximum is the total family contribution allowable and must include the annual administration fee. My maximum may be lower if:
  - I or my spouse earns less than $5,000
  - My spouse is a full-time student or incapable of self-care, or
  - I am married, but file a separate federal tax return.

  If any of the above exceptions apply, please call National Benefit Services (NBS), at 465-2284 or (855)399-3035.
  Care cannot be provided by my spouse or anyone I claim as a tax dependent.
- I cannot claim as a tax credit the same dependent care expenses that are reimbursed under this plan.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to the amount in my account balance after service has been rendered.
- I will be required to identify the person or agency performing the child care services to the IRS by providing his/her federal I.D. number or social security number.
- Any money left in my account after September 30th (after I have claimed all eligible expenses for that year), will not be reimbursed to me and will be **forfeited** to the State pursuant to the IRC. The IRS considers the date of a claim as the **date the service is rendered, not when the bill is actually paid.**

I understand that with the **Medical Spending Account**:

- Health-related expenses are reimbursable if they can be considered "deductible" medical expenses on my tax return as defined under section 213(d) of the Internal Revenue Code ("IRC"). Insurance premiums and unnecessary cosmetic surgery are examples of ineligible expenses. See, IRS Publication 502 for guidelines. I cannot claim on my tax return the same health care expenses that are reimbursed under this plan.
- The maximum I may contribute is $2,400 per plan year, plus the annual administration fee. If my spouse and I are eligible for the *Island Flex* Medical Spending Account, we may each contribute up to $2,400 per plan year.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to my annual election, minus previous claims paid.
- I may be eligible to continue in the Medical Spending Account on an after-tax basis through COBRA if a qualifying event occurs, such as separation from service.
- After September 30th, any amount left in my account up to $500 will carry over to the new plan year to be used towards expenses incurred in that new plan year.
- Any money which exceeds $500 left in my account after September 30th (after I have claimed all eligible expenses for that year), will not be reimbursed to me and will be forfeited to the State pursuant to the IRC. The IRS considers the date of a claim as the **date the service is rendered, not when the bill is actually paid.**

For more information on the Plan, please read the Hawaii Administrative Rules, Chapter 14-52 and the ***Island Flex*** employee informational booklet, or call NBS.