ThePensionBoards
United Church of Christ, Inc.

FSA Election and Compensation Reduction Agreement Form

Employer Name: _____ Employer ID #_____

Employer Email: _____

Employee Name: _____ Employee ID # _____

Employee Email: _____

FSA Plan Year _____, 20____ through _____, 20____

As an eligible employee in the Flexible Benefit Plan for UCC Ministries, I acknowledge that I have read the Highlights Brochure and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

☐ **My health coverage is through my spouse's/partner's* UCC Health Plan. Name of spouse/partner*:**

Spouse/Partner Name: _____

**I can only receive reimbursement for my domestic partner's medical expenses if I claim him/her for federal income tax purposes.*

☐ **I elect to receive medical reimbursements for the Plan Year.**

Salary redirection:

The amount of compensation redirection will be $_____ for the Plan Year.

NOTE: The annual Plan limit which may be allocated to the medical reimbursement account is: $3,050/year. Up to $610 of unused dollars elected can be carried over to the 2024 Plan Year. Other than this $610, the Plan is a "use it or lose it" program as outlined in our Plan document. You have until March 31, 2024, to submit expenses incurred prior to December 31, 2023, for reimbursement. The minimum amount you can elect is $100.

I understand that:

- Reimbursements will be available only for "qualifying medical care expenses." Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

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- As federal law does not recognize domestic partnerships, I can only receive reimbursement for my domestic partner's medical expenses if I claim him/her for federal income tax purposes.
- This section of the agreement will automatically terminate if the Plan is terminated or discontinued.
- If I elect not to continue, no further contributions will be made to the Plan on my behalf, although I may submit claims for expenses incurred prior to my date of termination.
- I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction or credit on my tax return.

☐ **I elect to receive dependent care assistance for the Plan Year.**

Salary redirection:

The amount of compensation redirection will be $_____for the Plan Year.

NOTE: The annual Plan limit that may be allocated to the dependent care reimbursement account is: $5,000/year. A grace period allows you to submit claims incurred January 1, 2023 - March 15, 2024, using remaining 2023 funds. You have until March 31, 2024, to submit claims for expenses incurred prior to March 15, 2024. The minimum amount you can elect is $100.

I understand that:

- Reimbursement will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan document, and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.
- I agree to provide the Administrator with the name, address and, if applicable, the taxpayer identification number of the service provider.
- This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.
- I will only be reimbursed for amounts up to the balance in my account at the time of my request.
- I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

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OTHER TERMS AND CONDITIONS

Please review carefully

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year unless I have a change in status and my election is consistent with such change.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event the Administrator believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.
- The amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year.
- Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected not to participate for the following Plan Year.
- **Because of the special tax treatment of the FSA, the IRS has a series of rules that must be followed. Therefore, my employer and I understand that contributions I make to the Flexible Benefit Plan for UCC Ministries must strictly be pre-tax deferrals. I also understand that my employer cannot make contributions on my behalf to my FSA and that all non-pre-tax contributions will be returned to the employer. In the event my employer makes any contributions to my account, and I am audited by the IRS, the Pension Boards- UCC will not be held liable.**

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

SIGNATURE	
Employee signature	Date
Accepted and agreed to by the Employer's Authorized Representative:	Date

Please return this signed and completed form by email to: info@pbucc.org; by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.