Flexible Benefit Plan Enrollment Form

July 1, 2026 PLAN YEAR
Administered by isolved

EMPLOYER: Roman Catholic Bishop - Stockton **PLAN YEAR ENDING: June 30, 2027**

1 *Employee Information* - Please print clearly

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS (optional)

2 *Make Your Elections* - Enter your election for each account.

Medical FSA

☐ **I elect to participate in the Medical FSA. The amount I elect for the PLAN YEAR is (min. $250 / max: $3,400):**

$_____ / Plan Year

Your annual election will be deducted from your pay in equal installments throughout the plan year.

☐ I **DECLINE** to participate in the Medical FSA

Dependent Care FSA

☐ **I elect to participate in the Dependent Care FSA. The amount I elect for the PLAN YEAR is (min. $250 / max. $7,500):**

$_____ / Plan Year

Your annual election will be deducted from your pay in equal installments throughout the plan year

☐ I **DECLINE** to participate in the Dependent Care FSA

3 *Direct Deposit Authorization* – Complete the banking information if you wish to establish direct deposit with isolved (or change your current direct deposit banking information on file with isolved).

By completing the banking information below, I hereby authorize isolved to deposit all reimbursements directly into my personal bank account at the financial institution named below. I understand that I may cancel this authorization at any time by notifying isolved. I further understand that I am responsible to notify isolved if, for any reason, my bank account information changes. If I do not sign up for Direct Deposit, I understand all reimbursements will be paid to me by check.

_____ Checking ☐ Savings ☐
Name of DEPOSITORY (Name of Financial Institution)

_____ _____
Bank Routing Number Account Number

4 *By signing below, you are agreeing to the terms and conditions printed on the back of this form.*

I, the undersigned employee, hereby certify that I have read and agree to all the "Terms & Conditions for Participation in the Flexible Benefit Plan" printed on the back of this Election Form. I hereby authorize my employer to deduct the amounts listed above from my compensation.

EMPLOYEE SIGNATURE:_____ **DATE**: ____/____/____

5 *Completed by Employer*

AUTHORIZED EMPLOYER SIGNATURE	EMPLOYEE DIVISION	BENEFITS EFFECTIVE DATE (May not precede the date employee signed form)	DATE OF HIRE	DATE OF 1ST DEDUCTION
_____	Name: _____ Unit #: _____			

Terms & Conditions for Participation in the Flexible Benefit Plan

I fully understand and agree that:

- I may never be reimbursed for expenses "incurred" (the date services are actually performed) prior to the later of, the date I am eligible to participate or the date I complete the enrollment form.
- Once made, my elections are "irrevocable" during the plan year unless I experience a "qualifying and related change in status". I understand that I must refer to my SPD for details.
- If I am an active employee as of the last day of the plan year, I will forfeit any remaining balance left in my reimbursement account(s) unless isolved "receives" my claim for qualified expenses by the last day of my "run-out period".
- If I terminate employment, or otherwise lose my eligibility to participate in the reimbursement accounts during the plan year, I may be required to submit claims for reimbursement shortly after losing my eligibility (refer to your SPD for the filing deadline if you terminate participation during the plan year). If I do not submit my claim for reimbursement by the deadline, I understand and agree that I will forfeit any remaining balance left in my reimbursement account(s).
- I may only receive reimbursements for qualified expenses incurred (date services are performed) during the plan year and while I am an active employee.
- I may be reimbursed for expenses incurred by myself, my spouse, my dependent children, and any other individual who qualifies as my federal tax dependent.
- I may never seek reimbursement before an expense is "incurred" (performed).
- By participating in my flexible benefit (cafeteria) plan, I may reduce my Social Security tax contribution, and therefore, could potentially reduce my future social security benefits.
- My employer may modify or revoke my elections at any time if required to maintain the Plan in compliance with all applicable provisions of the Internal Revenue Code (IRC).
- This agreement is subject to the terms and conditions of the Plan and revokes any prior agreement I may have completed.
- I must make a new election each year for my FSA accounts. My FSA elections will not automatically roll-over.
- To save taxes on my health insurance premiums, I must proactively check the box electing to participate in POP benefits each year. Prior to each subsequent Plan Year, if I do not check the box electing POP benefits during my open-enrollment period, I understand that my payroll deductions for group health insurance and/or my cost for specified voluntary health benefit plans will be taxed and I will not be permitted to change my election until the following Plan Year.
- I am responsible to determine if the tax benefits provided by the Dependent Care FSA are superior to the federal tax credit.
- I am responsible to reimburse my employer for any benefits received, taxes, penalties or interest that may be imposed if I knowingly violate the terms of the Plan.
- I have received a Summary Plan Description (SPD) for the Flexible Benefit Plan.