San Jose Evergreen Community College Flexible Benefit Plan/Transportation Plan Enrollment Form

Employee Information *Required (Please complete all sections)

First Name _____ M.I. _____ Last Name _____

Social Security Number: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

HR Use Only *Required

*Effective Date

*Date of first payroll contribution 03/10/2021

Division/Department information (if applicable)

Payroll Cycle (if your company has more than one pay cycle) 4

Dependent Care Reimbursement Account *Required (Please complete all sections) Limit: $5,000.00

_____ x 4 = _____

Per Pay Period Contribution | Number of Pay Periods | Total Annual Contribution

☐ NO, I do not elect to open a Dependent Care Reimbursement Account

Medical Care Reimbursement Account *Required (Please complete all sections) Limit: $2,750.00

_____ x 4 = _____

Per Pay Period Contribution | Number of Pay Periods | Total Annual Contribution

☐ NO, I do not elect to open a Medical Care Reimbursement Account

Parking Fringe Benefit Account *Required (Please complete all sections) Limit: $270.00/mo

N/A x N/A = N/A

Per Pay Period Contribution | # of Pay Dates per month | Total Monthly Contribution

☐ NO, I do not elect to open a Parking Fringe Benefit Account

Transportation *Required (Please complete all sections) Limit: $270.00/mo

_____ x 1 = _____

Per Pay Period Contribution | # of Pay Dates per month | Total Monthly Contribution

☐ NO, I do not elect to open a Transportation

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Authorization *Required if participating in the above accounts (Please sign & date)

I hereby elect to participate in my employer sponsored Benefit Program as listed on this form (herein referred to as the Plan/s), agreeing to be bound by all terms, conditions and limitations to the Plan/s and any and all separate plans, contracts, and documents made a part hereof. I agree to have my gross salary reduced by the amount of the cost of the benefits elected in cases where an employee contribution is noted. By reducing my gross salary, I understand that Social Security, Life and Disability benefits may also be reduced. I understand that any unused balance left in these benefits after the spending and submittal deadlines for the benefit have expired will be forfeited to the employer sponsor as required by law. If Carryover is a part of the employer sponsored plan design, only funds eligible for Carryover can be rolled forward into a future plan year. I understand that changes to these benefit elections may not be made in cases where such changes are prohibited by the Plan Document and/or that changes may be limited to qualified change in status events as defined in the Plan Document. I certify that I have been provided with the Summary Plan Description for the Plan/s that fall under Section 125. Finally, I certify that should the Plan mistakenly reimburse an expense (whether by my error or by an administrative error by another party), that it is my responsibility to reimburse the Plan/s as instructed. I understand that failure to do so is considered federal tax fraud and could result in additional civil penalties.

Employee Signature: _____ Date: _____

Clear Form

Flexible Benefits Card Terms and Usage Agreement

This form outlines terms and conditions that apply when using your Flexible Benefits Card. Please complete the form in its entirety and initial next to each term outlined as confirmation of your understanding of the outlined terms and agreement to adhere to the conditions contained herein. Completed forms should be provided to your Benefits Administrator and will be placed in your personnel file.

Company Name	Employee Name (please print)

PLEASE REVIEW AND INITIAL NEXT TO THE BELOW:

_____ I understand that I must retain copies of all receipts for purchases made with my Flexible Benefits Card in accordance with IRS regulations.

_____ I understand that, per IRS regulations, I may be asked to provide receipts for certain expenses.

*The IRS requires that all purchases that are not auto approved at the merchant's location via IRS (approved) approval standards or those that do not match a co-pay option available through the Employer Sponsored Health Benefits Program must be verified for eligibility by a third party.

_____ I understand that all communications regarding my Flexible Benefits Card will be delivered to me via email and have included the email address to which I wish to have all notifications directed above, including card usage alerts in accordance with Red Flag policies and requests for required documentation. I further understand that it is my responsibility to ensure that the goigoe.com domain is not blocked as spam by my email provider.

_____ I understand that if a receipt is requested, I have 21 days to reply and that I must complete the **Benefits Card Substantiation Form** available on www.goigoe.com. I further understand that usage of the incorrect form, specifically the Reimbursement Request Form will likely result in an inappropriate reimbursement pay out rather than resolving the transaction in question and may require action on my part to reimburse the Plan. If no receipt is received within this time frame my Flexible Benefits Card may be temporarily deactivated by the Plan Sponsor/Employer pending resolution of my transaction.

_____ I understand that if an ineligible purchase is made, I am responsible for resolving the transaction with my employer, which may (result in) repayment to the Plan.

_____ I understand that the Flexible Benefits Card may only be used for eligible expenses at MasterCard® acceptance locations that meet the IRS acceptance requirements. Locations include Hospitals, Physician Offices, Dental Offices, Vision Service Locations, and some Pharmacies.

*A list of eligible expenses and service providers can be found at www.goigoe.com

_____ I understand that my Flexible Benefits Card may decline at the point of sale for any of the following reasons: lack of funds available in my account, processing error by the Merchant, and/or processing error by MasterCard®.

Signature: Ready To Sign? Click To Print **Date:** _____

IGOE ADMINISTRATIVE SERVICES