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 03/08/2024

Division/Department information (if applicable) Associate Faculty

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: $3,200.00

_____ x 4 = _____ Minimum $240.00

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: $315.00/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: $315.00/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: _____