



## RCUH Flexible Spending Enrollment & Change Form (B-5F)

Submit via email: [RCUH\\_Benefits@RCUH.com](mailto:RCUH_Benefits@RCUH.com) or Fax: 808-956-5022

Employee Name: \_\_\_\_\_ RCUH Employee ID #: \_\_\_\_\_

### SECTION I: PRETAX Flexible Spending Plan Election & Compensation Reduction

**IMPORTANT:** **PRIOR** to completing this form, read the Election Information Sheet and RCUH's Flexible Spending Plan information brochure, OR refer to policy [3.530 RCUH Flexible Spending Plan](#). **Select an option and indicate your election(s) below:**

- New Enrollment
- Change Enrollment due to \_\_\_\_\_
- 1) *Your election change must be submitted to the RCUH HR Department no later than thirty (30) days after a family status change.*
- 2) *Supporting documentation must be submitted to make changes to your enrollment.*

**Healthcare Expense Reimbursement Account:** \$ \_\_\_\_\_ / Pay Period  
(Maximum contribution per pay period = \$114.58 / pay period)  
Maximum Annual Contributions: \$2,750 (2020)

**Dependent Care Expense Account:** \$ \_\_\_\_\_ / Pay Period  
(Maximum contribution per pay period = \$208.33 / pay period)  
Maximum Annual Contributions: \$5,000 (2020)

### SECTION II: PRETAX Transportation Benefits

**IMPORTANT:** **PRIOR** to electing, changing, or canceling this coverage, read RCUH policy [3.530A RCUH Flexible Spending Plan](#). These elections can be made at any time throughout the calendar year, but must be submitted to the RCUH HR Department at least **30 days PRIOR** to the requested effective date. **Select an option and indicate your election(s) below:**

<p><b>Parking Expense Reimbursement</b></p> <p><input type="checkbox"/> Enrollment \$ _____ / Month <i>(Maximum Annual Limit Per Month: \$270.00 / month)</i></p> <p><input type="checkbox"/> Change \$ _____ / Month</p> <p><input type="checkbox"/> Cancel: Parking Expense Reimbursement</p>	<p><b>Transit Expense Reimbursement</b> <b style="background-color: yellow;">Deduction occurs the month prior to coverage</b></p> <p><input type="checkbox"/> Enrollment \$ _____ / Month <i>(Maximum Annual Limit Per Month: \$270.00 / month)</i></p> <p><input type="checkbox"/> Change \$ _____ / Month</p> <p><input type="checkbox"/> Cancel: Transit Expense Reimbursement</p>
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**The Effective Date will be dependent upon submission of this form to RCUH Human Resources.**  
**RCUH will send a confirmation email with the effective enrollment date.**

### SECTION III: Employee Certification

- I acknowledge that I have reviewed and understand the options available to me for my Employer's Flexible Spending Plan pursuant to the following: (1) RCUH Policy 3.530 Flexible Spending Plan (2) Internal Revenue Service Code 125 for Pre-Tax Flexible Spending Accounts and/or (3) Internal Revenue Service Code 132 for Pre-Tax Transportation Accounts and will comply accordingly.
- I understand that my Employer makes no guarantee that any benefits I elect under this Plan will be excludable from my gross income for federal or state income tax purposes. I understand that it is my obligation to determine whether or not each payment made under this Plan is excludable from my gross income for federal and state income or Social Security tax and to notify my Employer if I am aware that any particular payment may not be excludable. I agree that if I receive one or more reimbursements under this Plan that are not excludable from income under the Internal Revenue Code, I will indemnify and reimburse my Employer for any tax that may be due on such reimbursement.
- I understand that failure to comply with the above or providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including termination of employment. Legal action may be brought against me and/or my Dependents/Spouse/Domestic Partner/Civil Union Partner for any losses, damages (including, but not limited to reasonable attorneys' fees and other legal expenses), financial or otherwise, due to false statements provided on this enrollment form or for failure to timely notify RCUH of changed circumstances as required.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
RCUH will only accept wet signatures and will validate the information prior to processing

*RCUH is committed to protecting the security of your personal information.*  
**Please submit via encrypted email to: [rcuh\\_benefits@rcuh.com](mailto:rcuh_benefits@rcuh.com) or FAX: 808-956-5022**

RCUH USE ONLY Authorized By:	Coverage Start	Input By / Date	Edit By / Date
Flex			