2026 Flexible Employees' Benefits Plan Enrollment Form

(Health Care and Dependent Care Reimbursement Accounts)

Return completed form to: Flexible Employees' Benefits Board, PO Box 304900, Montgomery AL 36130-4900
or seibenrollments@alseib.org *Read Email Disclosure
Telephone: (334) 859-6644 Toll Free: 1-866-836-9737 Fax: (334) 859-6581

EMPLOYEE INFORMATION (PLEASE PRINT)		
Name:	**Contract or Social Security #**	**Date of Birth**
Address:		
City, State and Zip:		
Work Phone (required):	**Home Phone:**	
Email Address:		

Health Care Reimbursement Account – Reimburses you for qualifying out-of-pocket healthcare expenses for you and your dependents during the plan year. (Minimum annual contribution is $120 and the current maximum is $3,400*) Note: health insurance premiums do not qualify for reimbursement. *The Flexible Employees' Benefits Board provides a $50 credit to any member who enrolls in the HCRA. Therefore, if you elect the maximum $3,400, the total contribution to your account will be $3,450.

- To enroll, enter the estimated annual amount you expect to spend for qualifying out-of-pocket healthcare expenses during the plan year.
- This annual amount will be divided by the number of pay periods you will be working during the plan year.

HCRA Annual Contribution Amount: _____

☐ **If you chose the current IRS maximum, check this box to indicate that you would like to increase your annual contribution in the event the IRS increases the maximum contribution amount before the beginning of the plan year.**

Do not include expenses for over-the-counter items unless approved by Optum Financial.
All enrollees will receive a flexible spending card. Please save all receipts.

Dependent Care Reimbursement Account – Reimburses you for qualifying dependent/child care related expenses during the plan year. Note: **a dependent's medical/dental expenses do not qualify for reimbursement under the DCRA.**

- To enroll, enter the estimated annual amount you expect to spend for qualifying dependent care expenses during the plan year.
- This annual amount will be divided by the number of pay periods you will be working during the plan year.

DCRA Annual Contribution Amount: _____ (max. $7,500 / $3,750 married filing separately)

Important – Read Carefully Before Signing

I understand that I cannot change or revoke any of my elections at any time during the plan year (Jan. 1- Dec. 31) unless I have a change in status as defined by the IRS. During the annual open enrollment period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Jan. 1-Dec. 31). I must enroll each year during the open enrollment period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year**. Up to $680 of unused funds remaining in the HCRA will "carry over" to the 2027 plan year after the 2026 filing period has expired, provided I re-enroll in the HCRA for the 2027 plan year. If I do not re-enroll for the 2027 plan year, all funds remaining in the HCRA after the 2026 filing period has expired will be forfeited. Even if I do re-enroll for the 2027 plan year, funds in excess of $680 remaining in the HCRA after the 2026 filing period has expired will be forfeited. Unused funds remaining in the DCRA are forfeited after the 2026 filing period has expired**.

I further understand and agree that if I receive payments that exceed the amount of eligible expenses or if I fail to provide proper documentation for a request for reimbursement or validation of a debit card transaction, I will be required to repay the excess reimbursement immediately after receipt of notification. If I fail to repay the excess reimbursement, the FEBB is authorized to: (1) offset the excess reimbursement against any other eligible expenses submitted for reimbursement (in accordance with applicable law); or (2) withhold the amount of the excess reimbursement from my pay (to the extent permitted by applicable law). If the FEBB is unable to recoup the amount of the excess reimbursement by any of these means, the amount of the excess reimbursement that could not be recouped will be reported to the Internal Revenue Service and applicable taxes will be withheld from my pay.

I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Employees' Benefits Plan and all information furnished is true and complete.

**Please use your own best judgment when sending this enrollment form or other information via the Internet to our e-mail address. E-mail sent via the Internet may pass through private and public networks with varying levels of security. Some networks may have taken steps to secure e-mail transmissions while others have not, thereby compromising the privacy and integrity of an e-mail. An e-mail may be copied, altered, or destroyed.*

Employee Signature: _____ Date: _____

If any of the following advisors assisted you, check the box by their name:

☐ **Genie Blake** ☐ **Kristen Henderson**