Missouri State Employees' Cafeteria Plan

2021 DEPENDENT CARE SPECIAL ELECTION

Use this form to newly enroll or increase your existing election for the Dependent Care FSA.

Name (Last, First, MI)		Social Security Number	Agency/Org or University
Street Address	**City**	**State**	**Zip**
Date of Status Change Event		**Daytime Phone Number**	

Your enrollment or election change will become effective on the 1st of the month following approval of the request.

The Dependent Care FSA can only be used to reimburse day care expenses incurred while you work.
Funds in the Dependent Care FSA cannot be used for medical expenses.

- **I am already enrolled in the Dependent Care FSA, and I wish to increase my election to the following:**

Deduct this amount from each remaining paycheck	# of paychecks remaining in 2021	New Annual Election Amount (cannot exceed $10,500)

- **I wish to newly enroll in the Dependent Care FSA for the following amount:**

Deduct this amount from each remaining paycheck	# of paychecks remaining in 2021	Annual Election Amount (cannot exceed $10,500)

- **DIRECT DEPOSIT:** I authorize Central/ASI to credit my account number _____ with _____ (name of bank), routing number _____ with my FSA payments. This account is a _____(checking, savings, money market) account. If necessary, Central/ASI may make deductions from my account for any payments credited to my account in error. Please attach a copy of a voided check. My administration fee will be $2.80 per month.
- Send a notice of payment with each direct deposit to the email address listed above.
- Do not send payment notices to me.
- Send notices of account activity via text messages to my cell phone. Please be aware that standard texting charges may apply, depending upon your cell phone plan. My cell phone number is: _____
- **CHECK:** I wish to have a check mailed to me for my FSA payments instead of direct deposit. My administration fee will be $4.00 per month.

I received the 2021 MoCafe Enrollment Guide & understand the benefits available to me as well as the other rights & obligations that I have under the Plan. I understand that during the above period, this agreement is irrevocable & cannot be changed except under special circumstances (see Change in Status Events) as outlined in the Enrollment Guide. I hereby agree to have my pay reduced by the amount(s) specified above. I also agree to pay the applicable administrative fees through payroll deduction. I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in the Plan through the end of the Plan Year (inclusive of any applicable Grace Period) or the end of my coverage period if I terminate during the Plan Year. All reimbursement requests must be postmarked by April 15, 2022 in order to be reimbursed. I further understand that any unclaimed amount remaining in my flexible spending accounts after that date will be forfeited.

_____ _____

Employee's Signature **Date**

Fax to: 573-442-4435 or **Mail to:** MoCafe, PO Box 858, Columbia, MO 65205-0858