MAIL OR FAX COMPLETED FORMS TO:
Baker Tilly Vantagen
c/o The Benefits Service Center
1200 Abington Executive Park,
Clarks Summit, PA 18411
FAX: 866-406-6946

State of Ohio
Department of Administrative Services
2024 Spending Account Enrollment Form
FSA Benefit Period Start Date: January 1, 2024
FSA Benefit Period End Date: December 31, 2024
Last Day to Incur Expenses for Reimbursement: December 31, 2024
Last Day to Submit Claims: March 31, 2025

Instructions

Complete this form only if you wish to participate in a health care, dependent, or limited care flexible spending account (FSA) or a commuter plan during the Open Enrollment period. These Spending Accounts will be administered by Baker Tilly Vantagen powered by their myFlexDollars platform.

The contribution amounts listed below apply to the FSA benefit period that runs from Jan. 1, 2024, to Dec. 31, 2024. When you make your election below, the amount you enter into the space provided applies to this benefit period. Deductions will be made from your pay based on the number of pay periods remaining in the year (24 when enrolling during the FSA open enrollment period).

Employee Profile *Please print

Effective date: _____ Employee #: _____

Employee Name: _____ Daytime phone #: _____

Address: _____ Email address: _____

_____ Date of Birth: _____

FSA Elections

To elect the FSAs, please indicate below the dollar amount that you would like to contribute to your account annually. When you enroll after the Plan Year Start Date, your per pay deduction amount is based on the amount you elect and the number of pay periods remaining until the Plan Year End Date.

☐ Yes, I would like to elect the health care FSA (HCFSA) benefit.

My **annual** contribution is $_____ (maximum of $3,050) ÷ 12/24 pay periods = $_____
Your Cost Per Pay Period

☐ Yes, I would like to elect the dependent care FSA (DCFSA) benefit.

My **annual** contribution is $_____ (maximum of $5,000) ÷ 12/24 pay periods = $_____
Your Cost Per Pay Period

☐ Yes, I would like to elect the limited purpose FSA (LPFSA) benefit.

My **annual** contribution is $_____ (maximum of $3,050) ÷ 12/24 pay periods = $_____
Your Cost Per Pay Period

Commuter Plan Election

☐ Yes, I would like to contribute $_____ per month to the pre-tax transit plan. (Up to a maximum of $300)

☐ Yes, I would like to contribute $_____ per month to the pre-tax parking plan. (Up to a maximum of $300)

I hereby authorize these elections for the 2024 benefit period. I authorize the State of Ohio to reduce my salary by the agreed upon amount. Before the start of each plan year, I will be provided with the opportunity to change my benefit election for the new benefit period. If I do not complete this form and submit a new election at that time, my Flexible Spending Accounts will be closed and no deductions will be taken during the new plan year.

Signature Date