# **2024** Flexible Spending Election/Change Form

**2024 Open Enrollment Flex Spending & Dependent Care Form**

☐ Salary ☐ Bargaining Employee ID Number _____

## SECTION A: YOUR PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: _____ Marital Status: ☐ Single ☐ Married

Phone #: _____ Email: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

| **Flexible Spending Account (FSA)** (For Medical Expenses) | **Dependent Care Assistance Plan (DCAP)** (Not for Medical Expenses) |
|---|---|
| ☐**Select FSA** ☐**Decline FSA** | ☐**Select DCAP** ☐**Decline DECAP** |
| Annual Contribution (Not to exceed IRS limits $3,200) $ _____ | Annual Contribution (Maximum Contribution: $5,000(Family) or $2,500(Individual) $ _____ |
| **For HR Official Use**: Number of Pay Periods_____ Contribution per pay period _____ | **For HR Official Use:** Number of Pay Periods_____ Contribution per pay period _____ |

## Certification

- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Any funds left in my Flexible Spending and/ or Dependent Care Accounts at the close of the plan year will be forfeited.
- I will receive a Optum Payment Card to access funds in my FSA account. I certify that:
- The card will only be used for eligible medical and/ or eligible dependent medical expenses.
- Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

_____ _____

Employee Signature Date

**To Be Completed by SMC HR**

Date change becomes effective with the Sibanye-Stillwater _____ mm/dd/yyyy

Date of Hire: _____ mm/dd/yyyy

Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions? ☐Yes ☐No

Signature of Human Resources Representative _____ _____ mm/dd/yyyy

INNOVATION COMMITMENT ACCOUNTABILITY RESPECT ENABLING SAFETY