



State of Connecticut Employee Enrollment Form

Flexible Spending Account (FSA)/Commuter

2026 Plan Year

Submit this completed form to State of Connecticut via one of the following methods:	Email	Fax	Mail
	Submit completed form to osc.supplemental-benefits@ct.gov	860-702-3556	OSC Employee Benefits Unit 165 Capital Avenue Hartford, CT 06106

EMPLOYER INFORMATION

Employer Name	State Of Connecticut	Employer TASC ID	4721-0392-1958
Plan Effective Date		First Payroll Date	

PARTICIPANT INFORMATION

All fields are required for account setup unless otherwise indicated. Information is confidential and is not used for marketing purposes.

First Name		MI		Last Name	
Employee ID or TASC ID		Email Address			
Primary Phone		Mobile Phone			
Primary Address	Address Line 1				
	Address Line 2				
	City		State		ZIP
Date of Birth		Hire Date		Payroll Frequency	

ELECTION INSTRUCTIONS

Prior to completing your election amounts on the next page, please refer to these instructions for entering elections under each applicable benefit account type:

- Healthcare Flexible Spending Account (Med Flex) Election:** The amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental, orthodontic, and eye care expenses. Participants may elect a maximum contribution of \$3,400 but must at least elect a minimum of \$520 if electing this benefit. Your election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement of eligible expenses on the first day of the plan year.
- Dependent Care Assistance Plan (DCAP) Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the plan year. Participants must at least elect a minimum of \$520 if electing this benefit. The maximum allowable amount under IRS regulations is \$7,500 per calendar year per family; \$3,750 per calendar year for married individuals filing single. Plan funds are available as they are contributed.

IMPORTANT NOTE

How Cafeteria Plans affect Social Security Benefits: Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs available under an FSA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.



ANNUAL ELECTIONS

I elect the following benefits and amount(s) to be deducted pretax:

		Employee Annual Salary Reduction Election Amount		Minimum Employee Annual Election		Maximum Employee Annual Election
<input type="checkbox"/> Healthcare FSA (Med Flex)	\$		\$	520	\$	3,400
<input type="checkbox"/> Dependent Care Assistance Plan (DCAP) – Daycare Expenses	\$		\$	520	\$	7,500

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Participant Signature

Date

Participant Printed Name

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request one additional card for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

Once you are enrolled, you may request a TASC Card for your spouse or dependent online in MyTASC or by calling Customer Care at 888-698-1429 for assistance.



COMMUTER BENEFIT ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable commuter account type:

- Transit Account Election:** Amount incurred per month to travel to and from work on mass transit facilities, or commuter highway vehicles. Examples of eligible expenses are vouchers, fare cards, or tokens for a bus, train, ferry, subway, or ride-share services (e.g., vanpool). Monthly limits apply.
- Parking Account Election:** Amount incurred per month for parking expenses at or near your place of employment or at a location from which you commute to work (e.g., ramp or park and ride). Monthly limits apply.

COMMUTER BENEFIT ELECTIONS

I elect the following amount(s) to be deducted pretax:

		Employee <u>Monthly</u> Election Amount		Minimum Employee Annual Election		Maximum Employee Annual Election
<input type="checkbox"/> Transit Reimbursement Account	\$		\$	20	\$	340
<input type="checkbox"/> Parking Reimbursement Account	\$		\$	20	\$	340

AUTHORIZATION

I understand and agree that my compensation will be reduced on a pretax basis in the manner and amount I have elected above. I understand amounts remaining in my benefit account(s) elected above that are not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws and that if I cease to participate in the plan such as due to termination of employment, unused funds will be forfeited. I further understand the pre-tax compensation deduction(s) elected above will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I certify that I will use the benefits elected above and use any debit card that may be provided under this plan only for purposes of reimbursing expenses that have been incurred for commuting to and from work at my Employer and that, if I receive Transit Passes under the plan, I will not transfer the Pass to anyone else. I understand that if I make false, fictitious, or fraudulent certifications, my employer may take an adverse employment action against me, up to and including termination of employment. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Participant Signature

Date

Participant Printed Name

**For enrollment assistance, call (toll-free) 888-698-1429.
Have your enrollment form, employer name, and the employer TASC ID ready.**

Find all IRS limits on our website at www.tasconline.com/benefits-limits.