FSA Enrollment Form

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: ____

Participant Name: ______________________________ Social Security #: ____________________

Address: ____

City: ______________________________ State: __________ Zip: ______________

Phone Number: ______________________________ Birthdate: ____________________

E-mail Address: ______________________________

EMPLOYER USE

Please complete for mid-year enrollments

Date of first deduction: ______________ Eligibility date: ______________

Pay Period:

☐ Weekly ☐ Semi-Monthly (twice a month)

☐ Bi-Weekly (every other week) ☐ Monthly

PREMIUM CONTRIBUTIONS

☐ I elect to participate (check all that apply)

☐ Health Insurance ☐ Group Life Insurance ☐ Disability Insurance ☐ Dental Insurance

☐ HSA Contributions ☐ Vision Insurance ☐ Other(s)__________________________

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

☐ I elect NOT to participate

MEDICAL REIMBURSEMENT ACCOUNT

☐ I elect to participate $____________ annually (may not exceed employer limit of $____________)
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

☐ This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (dental/vision only, if offered by your employer)

☐ I elect NOT to participate

DEPENDENT CARE ACCOUNT

☐ I elect to participate $____________ annually
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

☐ I elect NOT to participate

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year may be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature ______________________________________ Date ______________