Health/Limited/Dependent Care Flexible Spending Account (FSA) Enrollment Form

EMPLOYER MUST FILL-IN
Re-enrollment __ New __ Change __
Effective Date _____
1st Deduction Date _____
Payroll Mode W B S M Q
Division Code _____

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer: _____ **Employer ID#** _____

Member # _____ **Your Name** _____
(This may be your SSN or employer assigned number) (Last) (First) (MI)

Address _____ **City** _____ **State** _____ **Zip** _____-_____

☐ *Check if this address is new within last year.* **Date of Birth** ____/____/____ **Hire Date** ____/____/____

II. Election Information (Please check the appropriate box to indicate if you wish to enroll, or do not wish to enroll, and sign below.)

☐ Yes, I wish to participate in the **Limited Purpose and/or Dependent Care FSA** plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ Yes, I wish to participate in the **Heath Care and/or Dependent Care FSA** plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Flexible Spending Account (FSA) • If you are enrolled in a Health Savings Account, you cannot enroll in a Health Care FSA.	$_____.____	X	_____	=	$_____.____
Limited Purpose Flexible Spending Account • Only available if you are enrolled in a Health Saving Account.	$_____.____	X	_____	=	$_____.____
Dependent Day Care Flexible Spending Account • If married, this amount is less than my spouse's earned income. Please refer to the IRS guidelines for further information.	$_____.____	X	_____	=	$_____.____

I understand that:

- If enrolled in an HSA, I may only participate in a Limited Purpose FSA.
- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.
- If using the PayFlex Debit Card, I agree to use the card for eligible expenses only and retain all itemized receipts/statements. I agree to read and adhere to the cardholder statement I receive with the card and I understand the card is subject to inactivation if I do not comply with the provisions or upon termination of employment.
- Any expenses I pay for with the PayFlex Debit Card or for which I claim reimbursement will not have been nor will I seek to have reimbursed elsewhere.

III. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements.
This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement.
A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

✍ ***Employee Signature*** _____ ***Date*** _____ ***Rev.11/2014***