

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM



Employer: _____ Location/Group #: _____ Effective Date: _____
 Last Name: _____ First Name: _____ MI: _____
 Social Security #: _____ Date of Birth: _____ Day Phone #: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____ Email: _____

Health Care	Contribution/Pay Period	# of Pay Periods	Annual Election
(Maximum that can be elected is \$2,600)	\$ _____	_____	\$ _____
Dependent Care	Contribution/Pay Period	# of Pay Periods	Annual Election
(Maximum is \$5,000) (Maximum is \$2,500 if Married & Filing Separately)	\$ _____	_____	\$ _____

These benefits offered by my Employer have been explained to me and I understand that:

- Due to federal tax law, an election for a pre-tax benefit is irrevocable, except as otherwise indicated below. I will not be able to change or revoke my election on or after the first day of the Plan Year. UNLESS I have a Change in Family or Employment Status (i.e. marriage, divorce, death of a spouse or child, adoption, termination, or commencement of employment of a spouse or such other events that will allow a change or revocation under the Internal Revenue Code, as amended). The change must be caused by and be consistent with the Change of Family or Employment Status.
- I authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility, Medical Information Bureau, or other person, institution, or organization that has any knowledge or records of mine or my family's health, to make available such information to the Administrator. A photographic copy of this authorization shall be as valid as the original.
- Reimbursement shall only be made for eligible Medical and Dependent/Child Care Expenses. It is my responsibility to make my employer aware if I have reason to believe that I have received reimbursement for any expense that is not qualified under this plan. Upon demand, I agree to reimburse and indemnify my employer for any liability incurred for failure to withhold state or federal income taxes of FICA taxes for any reimbursement I may receive for non-qualified expenses, up to the amount of addition tax actually owed by me.
- The Patient Protection and Affordable Care Act of 2010 changed the rules for the purchase of over-the-counter (OTC) products using Flexible Spending Account pre-tax funds effective January 1, 2011. I can no longer use my account funds to purchase OTC drugs and medications unless I have a Note of Medical Necessity or a prescription from my doctor.
- If my Employer's FSA plan offers a Grace Period Extension and Run-Out Period at the end of the plan year, the total amount I have deducted for Medical Care FSA must be claimed in accordance with the guidelines under my Employer's FSA Plan Description, otherwise unused funds will be forfeited under IRS Rules. Any balance shall be retained by the employer who may use these funds to offset future administrative expenses. See your Employer's Plan Description to find out if a Grace Period Extension and Run-Out Period apply to you.
- If my Employer's FSA plan offers the Carryover Provision, I am permitted to carryover up to \$500 of unused funds in a Medical Care FSA to the immediately following plan year. See your Employer's Plan Document to find out if the Carryover Provision applies to you.
- The total amount deducted for Dependent Care Flexible Spending Accounts must be claimed in accordance with the guidelines under my Employer's FSA Plan Description or forfeited under IRS Rules. Any balance shall be retained by the employer who may use these funds to offset future administrative expenses.
- The ultimate obligation to make reimbursements under the Plan shall lie with the employer and not any service provider hired by the employer to assist in processing claims.
- My Social Security benefits may be reduced as a result of my election.

YES, I WISH TO ENROLL - SALARY REDUCTION AGREEMENT: I am making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified above, such amount to be deducted in approximately equal sums from my regular paychecks during the coming year.

Employee Signature _____
Date

NO, I DO NOT WISH TO ENROLL - WAIVER: I elect to waive all pre-tax benefits under the Flexible Spending Account. Except for a change in Family or Employment Status, I understand that I will not be able to elect pre-tax benefits until the anniversary date of the plan.

Employee Signature _____
Date