Flexible Spending Account Enrollment Form

Section I. Employee Information

Employer Name:		Plan Year:	Division #:
Employee Name:		Social Security Number:	
Street:	City:	State:	Zip:
Birth Date:	Hire Date:	☐ Male ☐ Female	Number of Pay Periods Per Year:

Section II. Employee Insurance Premium Contribution For Group Insurance

Your Group Insurance plan premiums are withheld pre-tax automatically. If you wish to pay taxes on your premiums, please contact your benefits coordinator to obtain a waiver form. Your election to pay your Group Insurance premium automatically continues each year unless revoked. You may revoke your premium election at the beginning of a Plan year or during the year should you have a qualifying "life event" that permits a mid-year change.

Section III. Health Care Flexible Spending Account – Please Choose One:

	Type 1.	**Type 2.**	**Type 3.**	
☐ I do not wish to participate.	I do not and will not contribute to a Health Savings Account in my name. I elect: ☐ General-purpose FSA for medical, vision and dental expenses.	My spouse contributes to a Health Savings Account. I do not contribute to an HSA. I elect General Purpose FSA (medical, vision, dental) for: ☐ Employee only ☐ Employee & children Note name of spouse: _____ Participant should not submit receipts for spouse.	I contribute and / or my spouse contributes to a Health Savings Account. I elect: ☐ Limited FSA for vision, dental, post-deductible medical expenses.	$ _____ per pay $ _____ per year

Section IV. Work Related Dependent Child (up to 13th birthday) or Adult Day Care Reimbursement Account

In order to participate in the Dependent Care Spending account, you must meet the following criteria:

- You and your spouse must both be working, seeking gainful employment or be a full-time student to be eligible to participate in the plan.
- Your contribution may not exceed your earned income, nor your spouse's earned income.
- In the situation of divorce, only the Custodial parent may use this account.
- If you are single or are married/filing a joint tax return, the maximum permissible election per calendar year is $5,000. If you are married/filing separately, the maximum is $2,500 per calendar year.
- You may change your dependent care election if you have a change in status such as a change in cost or change in provider. Changes must be made within 30 days of the event.

$ _____
per pay

$ _____
per year

Section V. Authorization

- **These are my pre-tax elections for the Plan year. I have read and understand the description of the Plan.**
- **I understand my insurance premium and Health FSA election may only be changed during the Plan Year for certain "life events" such as marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, or termination of employment. Changes must be made within 30 days of the event.**
- **Participation in this program may reduce my future Social Security benefits.**
- **I understand I must provide qualifying receipts in order to receive reimbursement for Sections III and IV.**
- **I understand that dates of service are eligible if incurred during the Plan year and while I am employed.**
- **I understand that unused balance left in my health care FSA and/or Dependent Care Account at the end of the Plan year cannot be returned to me.**
- **I authorize my employer to make payroll deductions of the amounts shown above from my earnings each pay period.**

Date _____ **Employee Signature** _____

Section VI. To Be Completed By Employer

Effective date of Participation:	Date of 1st payroll deduction:

If you have questions about the Flexible Spending Account, please contact FlexBank at 937.299.5515 or 888.677.8373.