Flexible Spending Account Enrollment Form

Employer name:			Plan Year:	
Last Name:	First Name:	M.I.:	□ Male □ Female	
			Social Security Number *(Must be provided)*	
Street Address:	City:		State:	Zip Code:
Home Phone Number: ( )	Date of Birth:	Date of Hire:	Division of Company:	□ Single □ Family
E-mail Address:				

Account Type	Election Amount
Health FSA (example: co-pays, eyeglasses, etc.)	**$_____Annual ($2,850 Maximum)**
Dependent Care FSA (For 13 years and younger and elder care)	**$_____Annual ($5,000 Maximum)**

Please Note: Your FSA benefit will start the first of the month following 30days of employment. For example, if your hire date is April 2nd your effective date will be June 1st. Claims reimbursement will bemade only for expenses incurred on or after the effective date.

AUTHORIZATION

I hereby elect the benefits indicated above. I have read and understand the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e., marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

Disclosure: By signing and dating this form, you here by give the Office of Employee Health and Wellness the permission to communicate to you through email to the email address you have provided above.

SIGNATURE OF PARTICIPANT_____**DATE** _____

Please return all enrollment forms to the Office of Employee Health & Wellness

For Office Use Only

Date Received: _____ TAMS ID: _____

Dept Number: _____ Total Amount Per Pay Period: _____

Effective Date: _____ Other: _____

Revised 5/2/2022