



# Flexible Spending Account Enrollment Form - 2022

Company Name _____		Group Number _____	Location _____
Social Security Number		<input type="text"/>	<input type="text"/>
First Name _____	MI _____	Last Name _____	
Address _____			
City _____		State _____	Zip Code _____
Gender _____	Marital Status _____	Date of Birth _____	

Date of Hire: \_\_\_\_\_

Flex Effective Date: \_\_\_\_\_

Payroll Schedule

Monthly       Semi-Monthly

Bi-Weekly       Weekly

<b>HEALTHCARE</b>	Contribution per Pay Period \$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	Number of Pay Periods Remaining in Plan Year X <input type="text"/> <input type="text"/>	Annual Election Amount = <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <small>CANNOT EXCEED \$2,750</small>
-------------------	---	---	---

**Are you enrolled in a High Deductible Health Plan with an HSA Account?**  YES  NO

**NOTE:** If YES is selected, you will be enrolled in a Limited Purpose Flexible Spending Account. This account may ONLY be used for eligible DENTAL and / or VISION expenses. It cannot be used for MEDICAL expenses covered by your HSA (Health Savings Account).

<b>DEPENDENT CARE</b>	Contribution per Pay Period \$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	Number of Pay Periods Remaining in Plan Year X <input type="text"/> <input type="text"/>	Annual Election Amount = <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <small>CANNOT EXCEED \$5,000 PER HOUSEHOLD</small>
-----------------------	---	---	---

### DIRECT DEPOSIT

If you do not make a selection or if you elect Direct Deposit and do not submit a voided check or deposit slip, you will automatically be reimbursed via a paper check mailed to your home.

**I elect to receive reimbursement from my flexible spending account for the plan year by:**

- Direct Deposit
  - Checking Account (attach a voided check)
  - Savings Account (attach a deposit slip)

**AUTHORIZATION:** Please select your enrollment option below, then sign and date your form and submit to your benefit services department.

I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year may be forfeited depending on the terms of my employer's plan.

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

I decline enrollment in my employer's Flexible Spending Account Plan.

---

Employee Signature

---

Date