FlexibleBenefit ADMINISTRATORS

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FSA Enrollment Form

Employee Information

Social Security Number: ____ Date of Birth: ____

Employer Name: ____ Dept/Location: ____ (Optional)

First Name: ____ Middle Initial: ____ Last Name: ____

Employee Home Address: ____

City: ____ State: ____ Zip: ____

Home Phone #: ____ E-Mail: ____

Help us go green! If provided, we will use your email as our primary method of contact.

Employment Date: ____ Plan Effective Date: ____ ☐ Male ☐ Female

Employer Information

(Employer to complete the information below.)

Date of 1st Payroll Deduction: ____ ☐ 12 Month Plan Year

Employee Plan Effective Date: ____ ☐ Short Plan Year

Employee Elections

(Employee to complete the information below)

A. Group Medical Premiums *(If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.)*

	Annual Election		# of Payroll Deductions		$ Per Pay Check
B. Health FSA		/		=	
Employer Contribution		/		=	
C. Dependent Care		/		=	
Employer Contribution		/		=	
D. Limited FSA		/		=	
Employer Contribution		/		=	
E. Administration Fee (if any)		/		=	
TOTALS					

☐ **No, I do not want to enroll**. If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer's plan allows).

☐ **Yes, I want to enroll** . The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

Signature: ____ Date: ____

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