Flexible Spending Account Enrollment Form

Name (Last, First, MI)	Social Security Number/Employee Number

Mailing Address	City	State	ZIP Code

Email Address	Date of Hire	Enrollment Status	Date of Birth
		☐ Open Enrollment ☐ New Hire ☐ Life Event	_____/_____/_____

__ Health Care Flexible Spending Account (FSA) Enrollment – For health care expenses __ Limited Purpose FSA For Dental and Vision only if you have an HSA		
Qualified expenses include medical, dental, vision and hearing expenses **for you and your tax dependents**. Include only your expenses after reimbursement from insurance plans in this election.		
Annual Salary Reduction Amount (Annual maximum of $2,850.00)	Per Pay Period $_____	Annual Election $_____

Dependent Care Assistance Program (DCAP) Enrollment – for child/elder daycare expenses		
Qualified expenses include charges for the care and well-being of a child or elder dependent while you work. **DO NOT include medical expenses for your dependents in the DCAP enrollment section. Please include these expenses in your enrollment for the Health Care FSA program above.**		
Annual Salary Reduction Amount (Cannot exceed $5,000, or $2,500 if married and filing separate income tax returns)	Per Pay Period $_____	Annual Election $_____

FSA Debit Card users retain your EOB or Statement of Service for Substantiation.

There is a $5.00 fee for additional or replacement card.

How do you prefer Flex Made Easy to reimburse you for your FSA claims? (select Direct Deposit or Check) **Direct Deposit: If you choose to receive reimbursement by direct deposit, select this box** ☐ Please use account information below to set up direct deposit (attach a voided check or copy of a check to this form)

Name of bank _____ 9-digit bank routing number _____ Account number _____

This is a ☐ checking account or ☐ savings account

Check: If you choose to receive reimbursement by check, select this box. ☐ Mail a check to my home address.

I understand:

- I have requested tax-free paycheck deductions based on the number of paychecks I expect to receive in the 2019 plan year. If enrolling during open enrollment, these deductions will start with my first paycheck in the 2019 plan year. If enrolling during the 2019 plan year, these deductions will start with the first paycheck of the month after this form is submitted and approved, through the plan year.
- The DCAP and FSA benefits, and my rights and obligations under this plan, as specified in the *Flexible Spending Account Enrollment Guide*.
- This form cancels any prior elections I have made under this plan, and cannot be changed except as stated in the *Flexible Spending Account Enrollment Guide*.
- Elections during open enrollment are effective on the first day of the Plan Year and are collected equally from each paycheck I will receive throughout the 2019 plan year, or during my initial contracted period of employment with my employer.

Employee signature _____ **Date** _____

Please return this form to Human Resources for processing.

Questions? FlexMadeEasy toll-free at 1-855-615-3679 or send an e-mail to info@flexmadeeasy.com