StirlingBenefits™
A 90 Degree Benefits Company

FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

Stamford Public Schools	☐12 Month Plan Year ☐Short Plan Year	**To be completed by Employer** Employee Effective Date for Plan: _____ Date of first Payroll Deduction: _____ For 25% Concentration Test - Is this employee considered a: Key Employee ☐ Yes ☐ No Highly Compensated ☐ Yes ☐ No

Employee Name – First, Middle Initial, Last	Social Security Number:	
Employee's Address: Street, City, State, Zip	Home Phone:	Cell Phone:

(Required) Employee E -mail Address for Plan notices and communications:

You may access your FSA Account online at: https://StirlingBenefits.wealthcareportal.com or download our Mobile app!

Birth Date: Month | Day | Year ☐ Male ☐ Female **Gender** ☐Single ☐Married **Marital Status**

Complete for additional debit card(s):

Spouse/Dependent(18-26 years of age) Name | Social Security Number | Date of Birth

Spouse and dependent debit cards will automatically have access to FSA Funds. Please Note: If you previously requested additional debit cards for your spouse or dependents, their debit card will automatically have access to new Plan Year elected funds. Please call our office to communicate changes.

Employer Plan Effective Date: **January 1, 2022**

Eligible Expenses incurred: **January 1, 2022 – December 31, 2022** must be submitted to the Stirling Benefits office no later than: **March 31, 2023**

☐ **Health Care Account (FSA):** (Minimum $100 / Maximum - $2,500)

If you, your spouse, or your employer on your behalf contribute to an HSA account, you may not participate in the Health Care FSA program.

Annual Election		# of Pays		FSA Deduction Per Pay
_____	÷	**21**	=	_____

☐ **Dependent Care Account (DCA):** (Minimum $100 / Maximum - $5,000)

_____	÷	**21**	=	_____

YES, I want to enroll. The IRS regulation states these 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 in order to receive payment. **4.)** You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. ***NOTE:*** Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice. **Signature: *x*_____ Date: _____**

No, I don't want to enroll. If a change of status occurs, I may have the right to sign on the plan at that time if my employer's plan allows.
Signature: *x*_____ Date: _____

Accepted and agreed to by the Company's Authorized Representative

By _____Date _____