

HEALTHY DOLLARS

FSA, LPFSA, DCA & HSA ENROLLMENT / CHANGE FORM

ENROLLMENT CHANGE TERMINATION EMPLOYER: _____

First Name:		Last Name:	
Social Security Number:		Date of Birth:	
Phone Number	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Email:	
Effective Date:		Mailing Address <i>(please include city, state & zip code):</i>	

DEPENDENT INFORMATION:

Last Name	First Name	SS #:	Date of Birth

ELECTION:

	Annual Election	Deduction Per Pay Period	First Payroll Date
Flexible Spending Account			
Limited Purpose FSA			
Dependent Care Account			
HSA**			

****Note-** To participate in the HSA plan, you must also complete the Avidia Bank HSA Healthy Dollars Form.

Authorization I hereby elect to participate in my employer's FSA and/or DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses.

I **ELECT** to participate in the Healthy Dollars Plan I **DO NOT** elect to participate in the Healthy Dollars Plan

Employee Signature: _____ Date: _____