Enrollment/Change Form

FLEXIBLE SPENDING ACCOUNTS (FSA)

Employer

Effective Date of Enrollment *(MM/DD/YYYY)*

Employee Name - *First Name, Middle Initial, Last Name*

Hire Date *(MM/DD/YYYY)*

Member ID *(set by employer. Typically an employee ID or SSN.)*

Birth Date *(MM/DD/YYYY)*

Street or PO Box

Email Address

City State ZIP

Phone Number

Employment Status: ☐ Full Time ☐ Part Time

PLEASE ENTER YOUR FSA ELECTION(S):

	Per Pay Deduction	Plan Year Election
☐ **Medical FSA** *Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.*		
☐ **Limited Medical FSA** (reimburses dental, vision and/or post-deductible expenses as allowed by your plan) *Note: You cannot elect this account if you elect a Medical FSA. You can elect this account if you are covered under an HSA. In order to accurately track eligible expenses, apply them to the correct deductible threshold and ensure reimbursement of eligible post-deductible expenses, you must indicate the level of coverage you have under your health insurance.* ☐ Single ☐ Family		
☐ **Dependent Care FSA**		

This is a:

☐ New enrollment ☐ Change in previous enrollment

IF THIS IS A CHANGE IN ENROLLMENT, please check the event that triggered this change:

NOTE: An election can only be changed if the change in status affects eligibility for that coverage. Any change in election must be consistent with the change in status and the change in eligibility

☐ Participant's termination of employment.

☐ Change in employment status of spouse or dependent (including termination or commencement of employment).

☐ Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).

☐ Change in number of tax dependents (including birth, adoption, placement for adoption, death).

☐ Change in work schedule (reduction/increase in hours by employee, spouse or dependent, including a switch between full-time/part-time, a strike/lockout, and commencement of or return from an unpaid leave of absence).

☐ Change in residence or worksite (of employee, spouse, or dependent).

☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).

☐ Change in dependent care cost or provider (for Dependent Care FSA elections only).

☐ Other:

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FLEXIBLE SPENDING ACCOUNT (FSA)

PLEASE CERTIFY THE FOLLOWING:

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may besuspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck onan after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature _____ Date *(MM/DD/YYYY)* _____

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

EMPLOYERS ONLY - This section must be complete for employee to be enrolled

Deduction Cycle: ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly

☐ Other: _____

Pay Date of First FSA Deduction(s): _____ FSA Pay Dates This Year: _____

Change in Health Insurance Level of Coverage: ☐ Single ☐ Family

Insurance Coverage Code: ☐☐☐☐☐☐

This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.

EMPLOYERS: Retain this document for your records. Do NOT send it to BRI. The required information should be sent to Benefit Resource via your normal file exchange process.