Enrollment/Change Form

Flexible Spending Accounts

Employee Name

Email Address

Street or PO Box

Phone Number

City State ZIP

Employment Status: ☐ Full Time ☐ Part Time

Please enter your FSA election(s):

	Total Calendar Year Amount	Per Pay Deduction Amount (total amount divided by 20 pay periods, or less if preferred)
☐ **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.* 2026 Maximum election amount: $3,400.00 2027 maximum election: TBD (estimated: $3,500.00)		
☐ **Dependent Care FSA** 2026 Maximum election amount: $7,500.00 2027 maximum election amount: TBD (estimated to be the same amount)		

Please certify the following:
I have received and read the material (available on the Mamaroneck UFSD website and at www.benefitresource.com) which explains flexible spending accounts. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for service 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 will be forfeited if expenses are not incurred by December 31st of the plan year and submitted for reimbursement by March 31st of the following plan year.

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 be suspended, and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper follow-up 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 follow-up documentation to Benefit Resource upon request.

Signature

Date *(MM/DD/YYYY)*