HEALTHY DOLLARS

Clear All Fields

FSA, LPFSA, DCA & HSA ENROLLMENT / CHANGE FORM

☐ ENROLLMENT ☐ CHANGE ☐ TERMINATION EMPLOYER: Rutland Public Schools

First Name:		**Last Name:**	
Social Security Number:		**Date of Birth:**	
Phone Number/Type:	Mobile	**Email:**	
Effective Date:		**Mailing Address** *(please include city, state & zip code)*:	

DEPENDENT INFORMATION:

Last Name	First Name	SSN #:	Date of Birth

ELECTION:

	Annual Election	Deduction Per Pay Period Based on 20 Pay Periods	First Payroll Date
Flexible Spending Account			
Limited Purpose FSA			
Dependent Care Account			
HSA*			

***FOR HSA ONLY:** 2027 annual contribution limit*: $4,500.00 (employee only) or $9,000.00 (employee plus one or family) **plus** $1,000" catch-up contribution if age 55 or older. No contributions for employees age 65 or older if participating in Medicare. *Limit includes employee and employer contributions

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.

Notice The intended use of this form is for your employer to capture your demographic data, enrollment elections and signature. Enrollment will need to be finalized on an enrollment spreadsheet (for OE) or in the employer portal (mid-year).

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

Employee Signature: _____ Date: _____

*** **For Accurate Enrollment Please Write Clearly** ***