FSA Enrollment Form 2022/2023

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: _____

Participant Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Birthdate: _____

E-mail Address: _____

Pay Period:

o Monthly (Circle how many months you are paid 12 or 11)

EMPLOYER USE

Please complete for mid-year enrollments

Date of first deduction: _____ Eligibility date: _____

MEDICAL REIMBURSEMENT ACCOUNT

o I elect to participate $_____ annually (may not exceed employer limit of **$2850.00)**
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

o I elect NOT to participate

DEPENDENT CARE ACCOUNT

o I elect to participate $_____ annually **(MAXIMUM $5000)**
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

o I elect NOT to participate

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year may be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____