FSA Enrollment Form

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:

☐ Weekly ☐ Semi-Monthly (twice a month)

☐ Bi-Weekly (every other week) ☐ Monthly

EMPLOYER USE

Please complete for mid-year enrollments

_____ _____

PREMIUM CONTRIBUTIONS

☐ I elect to participate (check all that apply)

☐ Health Insurance ☐ Group Life Insurance ☐ Disability Insurance ☐ Dental Insurance

☐ HSA Contributions ☐ Vision Insurance ☐ Other(s)_____

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

☐ I elect NOT to participate

MEDICAL REIMBURSEMENT ACCOUNT

☐ I elect to participate $_____ annually (may not exceed employer limit of $_____

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

☐ This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (see page 2)

☐ I elect NOT to participate

DEPENDENT CARE ACCOUNT

☐

Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays

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,

Employee Signature _____ Date _____