

# Enrollment/Change Form Flexible Spending Accounts

**Instructions:**

Check one box; complete the sections,  New Plan Year Election (New hires) (Complete sections I and II)  
Sign and date the form  Change for the Plan Year (Complete sections I, II and III)

**Section I – Employee Information** (Please print)

Social Security #	Location/Division		
Participant Name (Last, First, MI)		Date of Birth	
Home Address	City	State	Zip

**Section II- Account Elections** (Please complete items 1,2, 3 & 4)

1. Pre-tax Premium Election: I elect to have my required employee contributions withheld on a pre-tax basis for these coverages. (Availability of plans and contributions necessary to obtain coverage will be communicated by your employer prior to participation.)

Check the box for the coverage premium(s) you are electing  Medical  Dental

I do not wish to make a pre-tax premium election.

2A. Health Care Flexible Spending Account: I elect \$\_\_\_\_\_ per payroll or \$\_\_\_\_\_ for the plan year to be contributed on a pre-tax basis to my Health Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year. *I understand that by participating in the health care expense account I am disqualified from having a Health Savings Account ("HSA").*

I do not wish to participate in the Health Care Flexible Spending Account.

2B. Limited Health Care Flexible Spending Account: I elect \$\_\_\_\_\_ per payroll or \$\_\_\_\_\_ for the plan year to be contributed on a pre-tax basis to my Limited Health Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year. *I understand the Limited Health Care Flexible Spending Account is permitted-HDHP coverage for purposes of contributing to a Health Savings Account ("HSA").*

I do not wish to participate in the Limited Health Care Flexible Spending Account.

3. Dependent Care Flexible Spending Account: I elect \$\_\_\_\_\_ per payroll or \$\_\_\_\_\_ for the plan year to be contributed on a pre-tax basis to my Dependent Care Flexible Spending Account or, if an election change the amount elected is for the remainder of the Plan Year.

I do not wish to participate in the Dependent Care Flexible Spending Account.

**I hereby authorize my employer to deduct from my pay on a pre-tax basis the amounts elected above for the Plan Year. I understand that the payroll deducted amount will be available for the reimbursement of my qualifying expenses incurred during the Plan Year (or grace period, if part of the plan) and/or for the payment of my premiums in accordance with the terms of the formal Plan Documents and while I am a participating employee.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section III – Election Changes** (Check the proper box, indicate the date of the change, sign & date the section)

**Complete this section only if you are eligible to enroll mid-year or change your previous election due to a family status change. Mid-year enrollments and election changes MUST be requested within 30 days of the change.**

- |   |  |
|---|--|
| <input type="checkbox"/> Marriage   | <input type="checkbox"/> Divorce   |
| <input type="checkbox"/> Birth or Adoption of Child   | <input type="checkbox"/> Commencement or Termination of Employment of Spouse |
| <input type="checkbox"/> Change from Full-Time to Part-Time or Part-Time to Full-Time status by employee or employee's spouse |  |
| <input type="checkbox"/> Significant Change in Health Coverage due to Spouse's Employment                                     |  |
| <input type="checkbox"/> Change in Cost/Coverage to Daycare   | <input type="checkbox"/> Death of Spouse or Child                            |
| <input type="checkbox"/> Termination of Employment  | <input type="checkbox"/> Other _____   |

**I hereby revoke my previous deduction authorization for the current Plan Year and authorize my employer to make the payroll deductions indicated above for the remainder of the Plan Year.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section IV for Employer Use Only** (Employer Must Complete This Section For Any Changes)

Plan Sponsor / Employer Name \_\_\_\_\_ Location \_\_\_\_\_

Effective Date \_\_\_\_\_ 1<sup>st</sup> Payroll Change \_\_\_\_\_

Signature of Plan Administrator \_\_\_\_\_

**BENEFIT EXTRAS, INC. (Fax #952-435-8435)**