Enrollment/Change Form
Flexible Spending Accounts

Instructions:

Check one box; complete the sections, Sign and date the form	☐ New Plan Year Election (New hires) (Complete sections I and II) ☐ 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
Email Address			Date of Hire
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.**

2. 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 Flexible Spending Account I (and my spouse) am disqualified from having a Health Savings Account ("HSA").*

☐ **I do not wish to participate in the 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.

☐ Marriage
☐ Divorce
☐ Birth or Adoption of Child
☐ Commencement or Termination of Employment of Spouse
☐ Change from Full-Time to Part-Time or Part-Time to Full-Time status by employee or employee's spouse
☐ Significant Change in Health Coverage due to Spouse's Employment
☐ Change in Cost/Coverage to Daycare
☐ Death of Spouse or Child
☐ Termination of Employment
☐ 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 and/or Mid Year Enrollees)

Plan Sponsor / Employer Name _____ Location _____

Effective Date _____ 1st Payroll Change _____

Signature of Plan Administrator _____

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