eflexFSA

FSA Enrollment Form

Employee Information ***(please print clearly)***

Social Security # _____ Date of Birth _____

Employer Name _____ Dept/Location _____

First Name _____ Middle Initial _____ Last Name _____

Employee Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ email _____

❑ Male ❑ Female ❑ Single ❑ Married Spouse's Name _____

Employment Date _____ (Month Day Year) Plan Effective Date _____ (Month Day Year)

Employer Information *(Employer to complete the information below)*

Date of 1st Payroll Deduction _____ (Month Day Year) ❑ 12-Month Plan Year

Employee Plan Effective Date _____ (Month Day Year) ❑ Short Plan Year

Employee Elections *(Employee/plan participant to complete the information below)*

A. Group Medical Premiums – if you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.

	Annual Election	# of Payroll Deductions		$ Per Pay Check
B. Health FSA	$_____ /	_____	=	$ _____
C. Dependent Daycare FSA	$_____ /	_____	=	$ _____
D. Individual Health Policy	$_____ /	_____	=	$ _____
E. Administration Fee (if any)	$_____ /	_____	=	$ _____
TOTALS	$_____ /	_____	=	$ _____

❑ **No, I do not want to enroll**. If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer's plan allows).

❑ **Yes, I want to enroll**. The IRS regulations state four conditions. 1) Any expense you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

Signature _____ Date _____

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