Enrollment Form: Flexible Spending Account(s)

January 1, 2024 – December 31, 2024

GENERAL INFORMATION:

Employee Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

Date of Hire (MM/DD/YYYY): _____

FLEXIBLE SPENDING ACCOUNTS:

☐ I hereby elect to participate in the Health Care and/or Dependent Care Flexible Spending Accounts

	Annual Election
Health Care FSA ($180 minimum - $3,200.00 maximum)	_____
Dependent Care FSA ($180.00 - $5,000.00 maximum) (Day care expenses incurred during employment hours)	_____

Effective date of coverage: _____ The first payroll deduction will be on _____ , 20____

(Annual election deduction is distributed evenly over each pay period)

My pay schedule is: ☐ bi-weekly (20/24 pay periods) ☐ monthly (10/12 pay periods)

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

_____ _____

Employee Signature Date

WageWorks is the administrator of your Plan.
Please return this form to your Employer.