Flexible Spending Account Enrollment and Election Form

If you wish to enroll in a Flexible Spending Account via payroll deduction complete this form and return it to Lisa Steinbach Box 147.

Step 1: Participant Information (Employee)
*=Required Fields

* Accountholder Name (First, MI, Last)

*Address | *City | *State | *Zip Code

*Social Security Number | *Birth Date (MM/DD/YYYY)

*Day Telephone | *Hire Date | Employee ID

* Email Address

Step 2: Determine amount to be withheld from compensation

HEALTH FLEXIBLE SPENDING ACCOUNT
Annual Contribution Authorization (deducted on a payroll basis)

☐ Enroll me in the Health Flexible Spending Account **(Annual Amount)** $

DEPENDENT CARE REIMBURSEMENT ACCOUNT
Annual Contribution Authorization (deducted on a payroll basis)

☐ Enroll me in the Dependent Care Reimbursement Account **(Annual Amount)** $

Annual Contribution Limits

- Annual Maximum $2,550 for Health Flexible Spending Account
- Annual Maximum $5,000 for Dependent Care Reimbursement Account

Payroll Schedule Examples (For Reference Only)

Annual Contribution	Payroll Withholding			
	Weekly	Bi-Weekly	Semi-Monthly	Monthly
$500.00	$9.62	$19.23	$20.83	$41.67
$1,000.00	$19.23	$38.46	$41.67	$83.33
$1,500.00	$28.85	$57.69	$62.50	$125.00
$2,000.00	$38.46	$76.92	$83.33	$166.67
$2,500.00	$48.08	$96.15	$104.17	$208.33
$3,250.00	$62.50	$125.00	$135.42	$270.83
$3,350.00	$64.42	$128.85	$139.58	$279.17
$3,500.00	$67.31	$134.62	$145.83	$291.67
$4,000.00	$76.92	$153.85	$166.67	$333.33
$4,500.00	$86.54	$173.08	$187.50	$375.00
$5,000.00	$96.15	$192.31	$208.33	$416.67

Flexible Spending Account Enrollment and Election Form

Step 3: Employee Authorization

I understand the choices I have indicated above are IRREVOCABLE unless a "qualifying status change" occurs as defined by the Internal Revenue Service. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Service Code Section 125, if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for expenses are not filed within the required time period. I understand if I am terminated, discharged or have my hours reduced to less than 30 hours per week, I will be automatically terminated from the plan. If termination from the plan occurs either voluntarily or involuntarily, or if I stop all contributions:

- No benefits will be paid for any expenses incurred for dependent care and/or medical services after the termination date; and
- Any plan contributions made after the termination date will be refunded, subject to taxation.

I hereby authorize my employer to make adjustments to my payroll in accordance with the above elections. I have read and fully understand the rules both above and governing this plan. If for any reason the information provided above should change, I will immediately notify my employer.

*Employee Signature

*Date