

# Flexible Spending Account Enrollment and Election Form

Effective for Year 2023

If you wish to enroll in a Flexible Spending Account via payroll deduction complete this form and return it to Human Resources.

## 1. Participant Information (Employee)

\*Required Fields

* Accountholder Name (First, MI, Last)			Employee ID
* Address	City	State	Zip
*SSN	*Birthdate	*Email Address	
*Daytime Telephone	*Date of Hire		

## 2. Determine amount to be withheld from compensation:

### Annual Contribution Limits

- Annual Maximum \$3,050 for Health Flexible Spending Account
- Annual Maximum \$5,000 for Dependent Care Reimbursement Account;

**Health Flexible Spending Account**  Enroll me

Annual Contribution Authorization (deducted on a payroll basis)

Per Pay Amount \$ \_\_\_\_\_ Annual Amount \$ \_\_\_\_\_

**Dependent Care Reimbursement Account**  Enroll me

Annual Contribution Authorization (deducted on a payroll basis)

Per Pay Amount \$ \_\_\_\_\_ Annual Amount \$ \_\_\_\_\_

## 3. Employee Authorization

I understand the choices I have indicated above are IRREVOCABLE unless a "qualifying status change" occurs as defined by the IRS. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the IRS 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 a week, I will be automatically terminated from the plan. If termination from the plan occurs, either voluntary or involuntary or if I stop all contributions:

- No benefits will be paid for any expenses incurred for dependent care and/or medical expenses after the termination date
- 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 \_\_\_\_\_

\*12 month hourly employees will have 24 payroll deductions per year if enrolled January 1st.

\*10 month hourly employees will have 20 payroll deductions per year if enrolled January 1st.

\*12 month salaried employees will have 12 payroll deductions per year if enrolled January 1st.