Flexible Spending Account Enrollment and Election Form

Effective for Year_____

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

1. Participant Information (Employee)
*=Required Fields

_____
* Accountholder Name (First, MI, Last)

_____ _____ _____ _____
*Address *City *State *Zip Code

_____ _____ _____
*SSN *Birthdate *Email Address

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 (Per Pay) $_____
(Annual Amount) $_____

Dependent Care Reimbursement Account
Annual Contribution Authorization (deducted on a payroll basis)

☐ Enroll me in the Dependent Care Reimbursement Account (Per Pay) $_____
(Annual Amount) $_____

Annual Contribution Limits

- Annual Maximum $2,650 for Health Flexible Spending Account
- Annual Maximum $5,000 for Dependent Care Reimbursement Account

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 Play 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; 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:_____

**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.*