

<b>Employer Use Only</b>	
Employer ID Number	_____
Re-enrollment	<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/>
Effective Date	_____
1st Payroll Deduction Date	_____
Payroll Mode	W B S M Q
Division Code	_____

2024 FSA Maximum for Health Care is \$3200.00

**A. Personal Information** (Be sure to print clearly and complete each section.)

<b>Employer Name</b>			
<b>Employee First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Employee Social Security Number</b>
<b>Employee Street Address</b>			
<b>City</b>	<b>State</b>	<b>ZIP Code</b>	
<b>Employee email</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>Date of Hire (MM/DD/YYYY)</b>	

**B. Election Information** (Check the box to indicate if you wish to enroll or not.)

Yes, I wish to participate in the Benefit Choice(s) offered below. I authorize payroll deductions on a pre-tax basis in the amount(s) listed below. I know this election is for the entire Plan year.

No, I don't wish to enroll in either Benefit Choice at this time.


BENEFIT CHOICES	PER PAY PERIOD AMOUNT	NUMBER OF PAY PERIODS	PLAN YEAR AMOUNT
<b>Health Care Flexible Spending Account (FSA)</b> • Your employer's Plan sets the minimum and maximum contribution amounts, up to the Internal Revenue Service (IRS) limit.	\$ _____ . _____	X _____	= \$ _____ . _____
<b>Dependent Care Flexible Spending Account (DCFSA)</b> • Your employer's Plan sets the minimum contribution amount. The maximum contribution amount is \$5,000, as set by the IRS. • If you're married and your spouse is disabled, a full-time student earns less than you or if you file separate tax returns, your contribution limit may be lower. Review your Plan for more information. You can also refer to IRS Publication 503 at <a href="http://irs.gov">irs.gov</a> .	\$ _____ . _____	X _____	= \$ _____ . _____

**By signing this, you agree to the following statements:**

- I know this election is for the entire Plan year.
- I know that the only way to change my election during the Plan year is if I have a change in status or become ineligible to participate. The new election must be consistent with my change in status. I must apply for it within 30 calendar days of the change or as allowed by the Plan, and my employer must approve it.
- My employer will change or cancel this election, if needed, to comply with the Internal Revenue Code.
- If I elect the DCFSA, I understand that the IRS sets the maximum salary contribution allowed. My tax filing status and if married, my spouse's income limits the amount. I know I must file IRS Form 2441 with my income tax return.
- I know that I will forfeit any amounts left in my account at the end of the Plan year, unless my Plan allows carryover for the FSA. This is defined in the Plan.
- I know that funds can't be transferred between these accounts.
- I know that for FSA and/or DCFSA I need to complete and submit a new Enrollment Form for each Plan year. If I don't complete and return an Enrollment Form during Open Enrollment, I won't be able to participate in these accounts for that Plan year.
- If I elect the FSA and/or DCFSA, I understand that when I elect pre-tax salary deductions, Social Security and Medicare taxes are not withheld from those amounts.
- If I elect the FSA and/or DCFSA, I understand that I cannot claim the amount of salary deductions on my or my spouse's income tax returns.
- I know that if my employment ends, I can only claim medical expenses incurred through my period of coverage. This is defined in the Plan.
- I know that I have to include documentation with each claim to show that the expense is eligible for reimbursement.
- If I use my PayFlex Debit Card, I agree to use the card for eligible expenses only and to keep all itemized receipts and statements. I agree to read and adhere to the cardholder statement I receive with the card. I know the card may be turned off if I don't comply with the card rules or if my employment ends and I no longer have this account.
- When I use my PayFlex Debit Card or submit a claim, I haven't been reimbursed and I won't seek reimbursement elsewhere.

**C. Pre-Authorization for Direct Deposit** (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements. This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement. A "VOIDED" CHECK OR SAVINGS DEPOSIT SLIP MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

 **Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_