



## Flexible Spending Account (FSA) Enrollment Form

### I. Account Holder Profile Information

|   |  |                |             |      |
|---|--|----------------|-------------|------|
| First Name:   |  | Last Name:     |             | SSN: |
| Date of Birth:  |  | Email Address: |             |      |
| Mailing Address Line 1:   |  |                |             |      |
| Mailing Address Line 2:   |  |                |             |      |
| City:   |  | State:         |             | Zip: |
| Home Phone:   |  |                | Cell Phone: |      |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single |                | Employer:   |      |

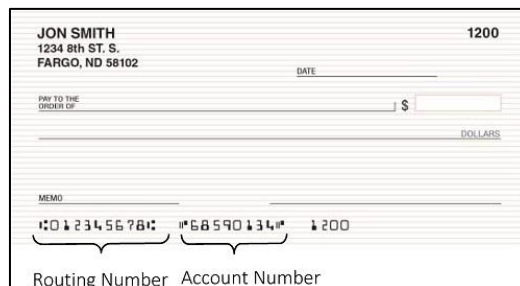
### II. Election

I authorize my employer to make the following pre-tax deductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event such as marriage, divorce, death, or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn't eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck.

|   |                                    |   |  |  |
|---|------------------------------------|---|--|--|
| Effective Date:   |                                    | 1 <sup>st</sup> Payroll Deduction Date: |  |  |
| Number of Payrolls this plan year: <input type="checkbox"/> 52 <input type="checkbox"/> 26 <input type="checkbox"/> 24 <input type="checkbox"/> 12 <input type="checkbox"/> Other # _____ |                                    |   |  |  |
| Healthcare Standard FSA   | Employee Annual Election: \$ _____ | Per Pay Period Election: \$ _____       |  |  |
| Healthcare Limited FSA<br><i>(Only if enrolled in a HSA)</i>  | Employee Annual Election: \$ _____ | Per Pay Period Election: \$ _____       |  |  |
| Dependent Care Account  | Employee Annual Election: \$ _____ | Per Pay Period Election: \$ _____       |  |  |

### III. Direct Deposit Setup

|   |        |      |
|---|--------|------|
| Bank Name: <input type="checkbox"/> Checking <input type="checkbox"/> Savings |        |      |
| Account Number:   |        |      |
| Routing Number:   |        |      |
| Address:  |        |      |
| City:   | State: | Zip: |



### IV. Debit Card

A Debit Card will automatically be issued in the account holders name and shipped to the address above. Once the enrollment is processed it should arrive within 10-14 days.

**Note:** To issue separate debit cards to any dependents 18 years of age or older, please complete the following section.

|       |      |      |               |
|-------|------|------|---------------|
| Name: | DOB: | SSN: | Relationship: |
| Name: | DOB: | SSN: | Relationship: |

### V. Authorization

|   |                               |
|---|-------------------------------|
| Signature _____ Date _____  | Employer Authorization: _____ |
| <b>**Please be sure to return this form to your employer for approval. **</b> |                               |