Limited Purpose FSA Enrollment Form

EMPLOYEE PROFILE

Employee Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

City: _____ Department: _____

State: _____ Effective Date: _____

Zip: _____ E-mail Address: _____

DEPENDENT CARD

I would like a dependent card ☐ **Yes** ☐ **No**

My dependent has a card. I would like to link it to the new plan year account. ☐ **Yes** ☐ **No**

Dependent Name: _____ Address: _____

Dependent DOB: _____ Social Security #: _____

ELECTION

I authorize my employer to reduce my salary by the amount(s) necessary to cover my participation in my company's Flexible Benefits Program as selected below. ***(Choose one)***

Weekly: ☐ Bi-weekly: ☐ Monthly: ☐ Annual: ☐ Other: ☐ Please Explain: _____

Reimbursement Account for Non-Reimbursable Limited Health Care Expenses FSA

This account is for participants in a HDHP and only covers eligible eye and dental care expenses.
(Maximum Salary reduction contribution that can be allocated is $3,200) $ _____

Total $ _____

AUTHORIZATION

- My Employer's benefits have been explained to me and I understand that:
  I can NOT change or revoke my election UNLESS I have a change in family status (marriage, divorce, death or a spouse or child, birth or adoption of a child, or termination of a spouse's employment) and my employer allows such changes.
- The total amount deducted must be used during the Plan year or forfeited under IRS rules. Certain exceptions may apply.
- Participation in the Flexible Benefits Plan may mean that I will be paying less Social Security Tax, which could slightly reduce my Social Security benefits when I retire.
- By my signature below, I certify that this information is correct, complete and meets all requirements for eligible health care and dependent care expenses.

Employee Signature _____ Date _____

Company Name _____ Group Number _____