



# 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 \$3,300) \$ \_\_\_\_\_

**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 \_\_\_\_\_