FlexibleBenefit ADMINISTRATORS
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FSA Enrollment Form

Employee Information

Social Security Number: _____ Date of Birth: _____

Employer Name: _____ Dept/Location: _____ (Optional)

First Name: _____ Middle Initial: _____ Last Name: _____

Employee Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ E-Mail: _____

Help us go green! If provided, we will use your email as our primary method of contac

Employment Date: _____ Plan Effective Date: _____ ☐ Male ☐ Female

Employer Information *(Employer to complete the information below.)*

ate of 1st Payroll Deduction: _____ ☐ 12 Month Plan Year

nployee Plan Effective Date: _____ ☐ Short Plan Year

Employee Elections *(Employee to complete the information below)*

A. Group Medical Premiums *(If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless yo notify your Human Resource or Personnel Department.)*

	Annual Election		# of Payroll Deductions		$ Per Pay Check
B. Health FSA		/		=	$0.00
Employer Contribution		/		=	$0.00
C. Dependent Care		/		=	$0.00
Employer Contribution		/		=	$0.00
D. Limited FSA		/		=	$0.00
Employer Contribution		/		=	$0.00
E. Administration Fee (if any)		/		=	$0.00
TOTALS					$0.00

☐ **No, I do not want to enroll**. If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer's plan allows).

☐ **Yes, I want to enroll**. The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses ou incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot hange or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see e Summary Plan Description for details.

Signature: _____ Date: _____