

# **FSA Enrollment Form**

## PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name:	
Participant Name:	Social Security #:
Address:	
City:	State: Zip:
Phone Number:	Birthdate:
E-mail Address:	EMPLOYER USE
Pay Period:	Please complete for mid-year enrollments
<ul> <li>Weekly          Semi-Monthly (twice a month)</li> </ul>	
<ul> <li>Bi-Weekly (every other week)</li> <li>Monthly</li> </ul>	
PREMIUM CONTRIBUTIONS	
<ul> <li>I elect to participate (check all that apply)</li> <li>Health Insurance</li> <li>Group Life Insurance</li> </ul>	sability Insurance o Dental Insurance
HSA Contributions     Vision Insurance     Oth	

- O HSA Contributions Vision Insurance Other(s)\_\_\_\_\_\_ The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.
- I elect NOT to participate

## MEDICAL REIMBURSEMENT ACCOUNT

- I elect to participate \$\_\_\_\_\_\_ annually (may not exceed employer limit of \$\_\_\_\_\_) Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments
- This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (see page 2)
- I elect NOT to participate

## DEPENDENT CARE ACCOUNT

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Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan,