

REIMBURSEMENT ACCOUNT ENROLLMENT FORM

To enroll, complete the following information, sign the form, and return it to your Human Resources Representative.

EMPLOYEE INFORMATION (Please Print)

Employer Name: _____ Date of Hire: _____

Employee Name: _____ Social Security: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Phone Number: _____ Email: _____

Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi Monthly ☐ Monthly

REIMBURSEMENT ACCOUNT

I, the undersigned employee, apply to participate in the Healthcare, Limited FSA and/or Commuter FSA Reimbursement Plan and agree with the Plan Document that with respect to, and in consideration of services to be rendered by the employee hereafter, the employee's salary will be reduced by the amount designated by the employee, such amount to be deposited to the employee's Medical, Limited or Commuter Reimbursement Account in this Plan in equal deposits and expended according to the rules applying thereto, for the purposes and in accordance with allocations below.

☐ I hereby elect **NOT** to participate in the Reimbursement Spending:

☐ I hereby elect to participate in the following Reimbursement Spending Accounts:

☐ **HEALTHCARE FSA (out-of-pocket medical, dental, vision, over-the-counter expenses) Maximum Election: \$3,400.00**

DEPENDENT CARE FSA (out-of-pocket day care expenses) Maximum Election \$7,500.00 (\$3,750.00 for married filing separately)

Amount Per Pay Period x Number Of Periods = Annual Election

☐ **Commuter FSA (parking and transit expenses)** Parking Transit
Minimum Election: \$0.00 Maximum Election: \$4,080 Annually (\$340.00 per month)

Amount Per Pay Period x Number Of Periods = Annual Election

I have been advised of the provisions of the Plan and understand the legal plan documents are controlling. I further recognize that I must allocate my Salary Reduction Account dollars in advance and that any dollars not used by the end of the Plan Year may be forfeited. Federal law does not permit an employee to revoke a benefit election once made for the current plan year, except as detailed in the Flexible Benefit Plan Document, and in the Summary Plan Description of the Plan, both available from the employer.

Employee Signature

Date

TO BE COMPLETED BY THE EMPLOYER

Department/Location: _____

FSA Effective Date: _____ FSA Payroll Contribution Start Date: _____

Employer Signature

Signature Date